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5 July 2003

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PSNC unveils new contract framework

A framework for the new pharmacy contract for England and Wales could have three key levels of service provision, PSNC has outlined as it started consulting with pharmacy contractors this week.

The basis of the proposed contract comprises:

- essential services – provided by all pharmacy contractors, would be the core service centred on dispensing
- enhanced services – provided by suitably trained accredited contractors, initially would be medicines use review. As pharmacists' experience improves, enhanced services would in time become essential services and new enhanced services would be added to the contract
- additional services – these would be services where the specification and value is agreed nationally, but would be commissioned locally by PCTs. These could become essential or enhanced services if successful.

At this stage, PSNC is consulting simply on whether this framework is what contractors would like to see. It has been working with the Department of Health and the NHS Confederation (representing patients and PCTs) to look at the sorts of services that should or could be included in the three service levels. However, it says it has not yet entered into any negotiations on finances, as the results of the current cost of service survey being undertaken in a sample of pharmacies are still to be evaluated.

At the first contract roadshow in London on Monday, attended by about 100 pharmacists, Steve Williams, former vice-chairman of PSNC and currently chairing the contract planning committee, emphasised that there would be no agreeing to a contract without the right finances being agreed. PSNC will base its funding negotiations on the formula:

cost of service + fair return = remuneration + profit on purchasing.

"We want the contract to be long lasting and to grow and develop over time," said Mr Williams. But he emphasised: "We are not going to agree the contract if we have not got agreement on funding."

There will be two ballots of pharmacy contractors. One will take place possibly in September on whether the basic framework is right.

If that meets approval then PSNC will add the detail and money to the structure and put this out to consultation with another ballot later in the year.

PSNC chief executive Sue Sharpe commented: "We really want to get your views ... we are trying to pull in views from all interested parties." Pharmacists can write to PSNC at the addresses in the panel above.

Essential services would be based on dispensing and include:

- giving patients advice about their medicines
- advising on possible adverse interactions
- recording of medicines dispensed
- providing compliance aids
- repeat dispensing
- signposting patients to other professional services
- complying with clinical governance requirements
- public health
- a requirement for opportunistic interventions such as advising on smoking cessation, flu vaccination or appropriate use of antibiotics
- collection of waste medicines for disposal (by the PCT)
- sharps disposal.

Enhanced services would start with medicines use review, reviewing patients' medicines on a one-to-one basis. **Additional services** could include many areas, such as substance misuse management, anti-coagulant services, methadone consumption supervision, care home services, medicines management, needle exchange, smoking cessation, EHC provision, palliative care etc.

At present, the DoH is keen to see minor ailments management (where patients can receive advice and treatment on the NHS via the pharmacist) kept as an additional service, said Mr Williams, although he would like to see this as an essential service.

For more information:

www.psnc.org.uk

contract.comments@psnc.org.uk

Write to: PSNC, 59 Buckingham Road, Aylsbury, Bucks, HP20 2PJ.

Final Charter roadshow

Nearly 50 pharmacists, including Royal Pharmaceutical Society staff and Council members attended the Society's last Charter roadshow this week in London.

Following presentations from RPSGB president Gill Hawksworth, and secretary and registrar Ann Lewis, the Society's Charter expert Marcus Longley led a discussion session.

Dr Gordon Applebe, a former Council member, said the Government should take over regulation and let the Society remain as a professional, representative body. "The Society wants to have its cake and eat it," he said. However, he agreed that a new Charter was important as a safeguard for the profession. Dr Applebe called for the Society to circulate a proper draft of the proposed new Charter and not just the "intentions" of what might be included in the new Charter.

Hertfordshire's Graham Phillips asked why the Council chose to have a new Charter when the original one could be amended.

"Was a new Charter chosen to avoid the democratic necessity to get 75 per cent of members to agree to an amended version?" he said. Ms Lewis replied that Council was unanimous in its decision to have a new Charter and that it was "the best option".

Dr Hawksworth reassured members that Council was listening to their concerns. "We are listening – we've listened to what you've said this evening. And we are listening to what the membership are saying to us – believe me."

Nearly 50 Avicenna delegates took part in a workshop on measuring obesity, the principles of achieving a healthy diet and diagnostic monitoring. Led by Avicenna's professional development adviser, Hemant Patel, the 'Worth your weight in gold' course showed delegates how these services can be implemented in the pharmacy setting, what pharmacists should charge for input and services, the potential pharmacy market and the opportunities for profit generation. Dr Terry Maguire from Queen's University, Belfast, along with Hackney GP and obesity specialist Dr Jim Lawrie and Whittington Hospital's head dietician Kyri Shiamtanis, gave presentations at the Roche sponsored course last Sunday

Around 700 (out of a million) medical artefacts collected in the early 20th century by pharmacist and co-founder of Burroughs Wellcome, Henry Wellcome, have gone on show at the British Museum in London. The exhibition, open until November 16, includes exhibits such as an English tobacco resuscitator kit, used to revive the 'apparently dead' by blowing smoke up the rectum or through the nose or mouth, glass eyes (pictured) and a (male) anti-masturbation device

PRACTICE

DT error hits contractors

Contractors are losing a substantial sum of money each time they dispense prescriptions for Somatuline (lanreotide) Autogel due to a *Drug Tariff* anomaly, a pharmacist is warning.

Pharmacists receive no discount from wholesalers when purchasing Somatuline Autogel as it is a fridge line but, as the *Drug Tariff* does not list it in the Zero Discount list, the Prescription Pricing Authority automatically applies a discount clawback. For the average contractor, this represents a loss in the region of £80 each time they dispense Somatuline Autogel, suggests Kenneth Schofield, a pharmacist from Swindon in Wiltshire.

Mr Schofield has contacted the National Prescription Research Centre and the manufacturer Ipsen to bring the matter to their attention. Ipsen regional business manager Nigel Homer said he has contacted the NPRC to request that Somatuline Autogel is added to the ZD list, which he believes will happen within a month.

A PPA spokesman confirmed that it had received a request from the Department of Health to add Somatuline Autogel to the ZD list but said that there had been no decision on whether it would happen or not.

Regarding prescriptions already submitted to the PPA for Somatuline Autogel, the PPA spokesman said that there is nothing that can be done. However, PSNC information and technical services head, Gordon Geddes, said contractors who have suffered a financial loss as a result of dispensing this product should write to their PCT asking for a statutory payment, although PCTs are not obliged to make this payment.

ABPI

Pharma industry wants information access

Patients should be able to access "good quality information" about their prescribed medicines from pharmaceutical companies, the ABPI is claiming.

Responding to last week's Commons public accounts committee report (*C&D, June 28, p8*), which criticised the quality of many of the information leaflets provided to patients about their medicines, Dr Trevor Jones, the ABPI's director-general, said: "It is high time that patients were allowed to access good quality information about the medicines they have been prescribed.

"We readily accept that more and better information could be provided to patients, but the fact is that the law prevents us from doing this."

The Association says the content and appearance of patient information leaflets is heavily regulated and pharmaceutical companies would like to "supplement these formulaic leaflets with additional information about their medicines".

An ABPI spokesman suggested that patients should have access to information from the people who developed the medicine.

The RPSGB was unable to say whether it felt drug companies should be able to supply additional information on their medications, or whether this should only come from health professionals.

- Responding to criticism that the MHRA is entirely funded from pharmaceutical industry fees, the ABPI agreed "100 per cent funding may no longer be appropriate".

Draft contract framework imminent

The Government hopes to publish a draft framework for a new pharmacy contract before the summer recess, the health minister with responsibility for pharmacy confirmed this week.

Rosie Winterton said the proposals would be published before July 17, at about the same time as the Government's response to the OFT report on deregulating community pharmacies.

Ms Winterton, addressing Tuesday's annual meeting of the All-Party Pharmacy Group, whose work she described as "incredibly impressive", said that she hoped the framework for the new contract would be in place by 2004.

The Government would also be publishing a consultation paper building on the vision of *Pharmacy in the Future*, incorporating new ideas as well as looking at what had been achieved so far.

Ms Winterton said that, in her new post, she had intervened twice in Parliament on community pharmacists' behalf. She had "absolutely signed up to" the notion that pharmacists were not shopkeepers but part of the primary healthcare team.

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in June:

- Polycystic ovarian syndrome (1272)
- Foetal development part 2 (1273)
- Alzheimer's part 1 (1274).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on *www.dotpharmacy.com*. Further information is available from Mary Prebble on 01732 377269. Genus Pharmaceuticals supports the MCQ and telephone marking service.

Scots debate health plan

The pharmaceutical industry, NHSScotland and the voluntary sector have met to discuss whether a Scottish proposal for a wider range of health services delivered locally in communities could successfully put patients at the centre of healthcare improvement.

Lothian Health Board chief executive, Professor James Barbour, said the proposed actions detailed in *Partnership for Care*, launched in February, would definitely make a difference to patients and a number of measures were already in place to ensure their implementation.

He believed that all front line staff including pharmacists should be empowered in order to facilitate decision-making at the "sharp end".

Scottish Executive principal pharmaceutical officer Alison Strath said it was important for patients to take on ownership of their ill health.

Pharmacists already play an important part in supporting self-treatment, a role that was about to expand with the addition of supplementary and, ultimately, independent prescribing. She said much of drug-related morbidity was preventable, and that lack of concordance was often due to misunderstandings following poor communication between health professional and patient.

ABPI deputy director-general Andrew Curl assured delegates at the meeting held in Edinburgh last Friday that the ABPI's members looked beyond short-term profit.

Guild 'cautious' over hospital deal

The Guild of Healthcare Pharmacists has "cautiously" welcomed the increase in pharmacist salaries of 10 per cent over the next three years, which was announced last week.

GHP section general secretary Barry Jones said the rise, which translates to 3.225 per cent per year and is backdated to April 1, was "not a bad deal". However, this was dependent on inflation not rising greatly in the second and third years of the pay award, as the DoH has made it clear it will not review the award next year, he suggested.

Mr Jones added that the awards were unlikely to increase retention and recruitment of pharmacists, as salaries in the hospital sector still lag behind community pharmacy.

Between 1995 and 2002, the number of hospital pharmacists rose 39 per cent to 10,083 (whole-time equivalents).

Rowlands have introduced these eye-catching Common Complaints Display Cards into their pharmacies. The cards, similar to bookmarks, cover a multitude of minor ailments including sore throats, eye problems and upset stomachs. They include advice on how to treat the symptoms as well as recommendations for branded medicines that may help. Kenny Black, commercial director of Rowlands Pharmacy, said: "For complete reassurance the final port of call would be our pharmacist"

SURVEY

Error study gets cash aid

A University of Manchester study examining why errors occur in community pharmacies is to get £75,000 funding from national pharmacy organisations and the Government.

The Community Pharmacy Research Consortium (consisting of the CCA, the NPA, the RPSGB and the Scottish Pharmaceutical General Council) will, along with the DoH, fund the university's pharmacy and psychology departments' study into the types of errors and near misses that occur in community pharmacies and the causes of these incidents.

RPSGB practice research head Dr Sue Ambler said: "The focus of the research will be the systems understanding why errors occur rather than blaming individuals, and looking at the underlying circumstances such as workload and staffing levels." Research results will be available next year.

LEGAL

Aspirin law for under-16s

Legislation ensuring that the packaging for aspirin carries the latest health warning was laid before Parliament last Friday and will come into force on October 1.

After this date, all aspirin products must include the warning, "do not give to children aged under 16 years, unless on the advice of a doctor", due to the risk of Reye's syndrome. Previous guidance said that aspirin should be avoided in children under 12.

The NPA, in its July *Supplement* has reminded pharmacists to review protocols for non-prescription medicines and ensure staff are aware of the new advice.

LEGAL

CSA takes fraud role

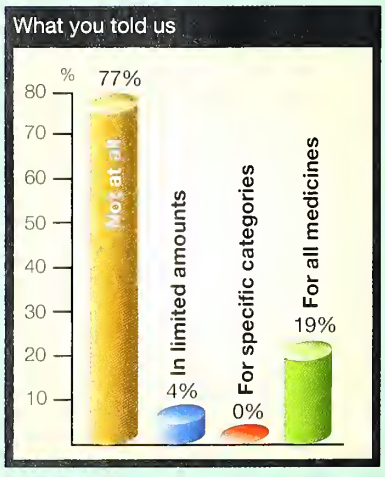
The Common Services Agency in Scotland is taking over certain fraud roles from health boards and NHS trusts following legislation that came into force last month.

Scottish Statutory Instrument 2003 No 306 permits the CSA to prevent, detect and investigate fraud in medical, dental, ophthalmic and pharmaceutical services.

Questiontime

Sponsored by UniChem

Last week we asked you: Do you think primary care organisations should be able to centrally purchase medicines? You replied (see right):



This week's question: What do you think of PSNC's proposed framework for the new pharmacy contract?

- Acceptable
- Too many service tiers
- Need pay details before deciding
- Undecided

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on July 8 to cast your vote. We will publish the results in *C&D*, July 12.

no tears

because his allergy relief is reliable

because it's once a day

because it helps to avoid drowsiness*

because it doesn't cost the earth**

because it's part of the Piriton family

Piriteze allergy tablets

one a day

cetirizine dihydrochloride

*Piriteze does not cause drowsiness in the majority of people at the recommended dose

**Piriteze 30 tablet pack compared with other brands of cetirizine dihydrochloride on a cost per day basis

Piriteze Allergy Tablets Product Information: Presentation: Film coated tablets containing 10 mg of etirizine dihydrochloride. **Uses**: Symptomatic treatment f perennial rhinitis, seasonal allergic rhinitis and chronic diopathic urticaria. **Dosage and administration:** Adults ncluding the elderly) and children 12 years and over, 10 ng daily. Children under 12 years not recommended. **Contraindications:** Hypersensitivity to any of the constituents of the formulation and lactating mothers. **Precautions:** Use half dose in patients with renal impairment. Advisable to avoid excessive alcohol consumption. Should not be used during pregnancy unless clearly necessary. Exceeding the recommended dose may effect driving or operating machinery. **Side effects:** Occasionally mild and transient subjective side effects such as drowsiness, headache, dizziness, agitation, dry mouth and gastro-intestinal discomfort. Convulsions reported very rarely. **Legal category:** P (30 tablets) and GSL (7 tablets). **Retail selling price:** (ex VAT). P (30 tablets): £7.28. GSL (7 tablets): £3.40. **Product licence number:** PL 0289/0388. **Licence holder:** Approved Prescription Services Ltd, Brampton Road, Hampden Park, Eastbourne, BN22 9AG, England. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex TW8 9GS, U.K. **Date of preparation:** December 2001. Piriteze is a trade mark of the GlaxoSmithKline group of companies.

Scots courses intake up

The number of Scottish pharmacists undertaking post-qualification education programmes in 2002-2003 rose by up to 12 per cent on the previous year, according to the NHS Education for Scotland (NES) Pharmacy's first annual report.

Attendances at national direct learning courses rose 12 per cent to 618, while local and direct learning course attendances were up 6 per cent and 7 per cent to 2,670 and 3,288 respectively. Target audience numbers for last year were 2,700 community pharmacists and 755 hospital pharmacists.

Rose Marie Parr, acting head of NES Pharmacy, said: "Pharmacy, with NES, has been sustained and developed in line with the educational requirements for the NHS and the profession. Pharmacists have continued to participate in CE and CPD activities, and we welcome the continued attendance at SCPPE programmes and uptake of distance learning packages."

For more information:
www.nes.scot.nhs.uk

Marion Hetherington (right) of Eldon Laboratories received a City & Guilds Medal of Excellence for outstanding performance in her NPA Pharmacy Services Level 3 NVQ last week. Marion, whose work was described by one of the judges as "by far the best portfolio for pharmacy services that I encountered this year", is one of only 109 medal winners from over 750,000 eligible candidates. In addition, Marion has been invited to meet City & Guilds' president HRH the Duke of Edinburgh at Buckingham Palace on July 16. Marion is pictured receiving her award from Lesley Johnson, head o the NPA's education and training department

Help for herbal product registration

The British Herbal Medicines Association has published information to help register herbal products in response to a European Directive due next year calling for a traditional herbal products registration system with the same quality standards as for medicines.

The Guide to Traditional Herbal Medicines, which gives information on accepted traditional uses of medicinal plants in Europe, allows manufacturers to produce evidence that the herbal product has been used for several years for the proposed indications, without carrying out extensive clinical trials for efficacy. Medicines and Healthcare products Regulatory Agency chairman Professor Alasdair Breckenridge said manufacturers would be able to quote the guide as evidence of traditional use.

Plants such as echinacea will have their traditional uses listed

The guide includes monographs for over 260 herbs used in the UK, listing the indications described in official texts such as *British Pharmacopoeia*, *Martindale* and *Commission E Monographs*. The BHMA hopes to publish more guides in due course.

PAGB confident in 'difficult' market

The trade association for OTC medicine and food supplement manufacturers expects P to GSL switches to drive future sales after its latest report showing low single digit growth in the pharmacy and grocery OTC medicines market for the past two years.

Mike Owen, the Proprietary Association of Great Britain's communication and commercial director, said that although the UK OTC market continues to be difficult ... with disappointingly low growth ... [the] flat overall picture disguises a few important trends in the market".

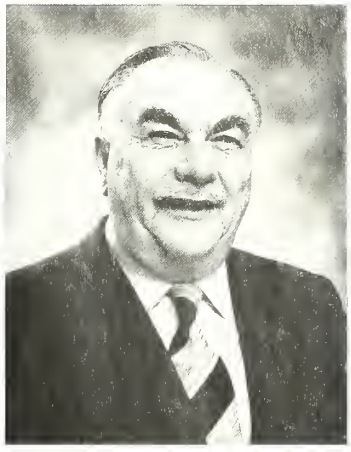
The UK's OTC medicines and food supplements market was valued at £1.76 billion (IR data) for the year ending December 2002, an increase of 1 per cent over 2001 and similar to a 2.4 per cent growth between 2000 and 2001, according to the PAGB's annual report published this week.

Although some major brands were subjected to substantial price reductions due to the loss of RPM, Mr Owen said this was compensated for by growth in categories such as anti-allergy and smoking cessation, which was driven by consumer demand and greater product availability due to license reclassifications.

The continuing rise in the health consciousness of UK customers along with further P to GSL switching "augur well for future overall growth", Mr Owen added.

Pain relief medicines, which represent 23 per cent of total OTC sales, grew 2.1 per cent to £415.5m last year, while cough/cold/sore throat remedies, which represent around one in five OTC sales, fell 3.7 per cent in value to £339m. Vitamins, minerals and supplements, however, fell 5.6 per cent in value to £276.6m, or 15 per cent of total market value.

Mervyn Madge



Mervyn Madge *FRPharmS*, of Budleigh Salterton, Devon, has died. Having registered in 1933, Mr Madge became a prominent pharmacist with many interests and served as an honorary auditor of the RPSGB until as recently as 2002. He was made a Fellow of the Society in 1969.

Mr Madge's distinguished career ranged from being a long and active member of the Plymouth Branch to being elected to the Society's Council. He served as chairman of the Institute of Pharmacy Management International, as vice-president of the British Society for the History of Pharmacy, chairman of the Society' Agricultural and Veterinary Medicines Group, and as chairman of the British Homocopathic Association.

He was co-founder and first president of the Rural Pharmacists' Association, and was co-founder of the College of Pharmacy Practice. Mr Madge was also a member of the Plymouth chamber of commerce and industry and a past chairman of the Plymouth disablement employment advisory committee.

In recent years Mr Madge became a prolific letter writer to the pharmacy press. Using his skill as raconteur, Mr Madge authored *The Tamerton Treacle Mines and other tales of Cornwall and the West Country* in 1984, which told of how the Tamerton miners extracted treacle from their mines using a gravitational drip process.

Boots' stores go up for sale...

Boots has put an undisclosed number of stores up for sale as going concerns after identifying some locations where customer demand has changed, through competition or demographics.

A spokeswoman said the sell-offs were nothing to do with the proposed OFT report into the deregulation of pharmacies, but that Boots was "reviewing our portfolio to be in the right places where our customers want to come to us for healthcare and to shop".

Boots claims this will allow it to reinvest in areas of future healthcare growth, and has announced plans to invest £150 million in its pharmacy and healthcare business. This will cover new and refurbished stores, new-style dispensaries and the roll-out of more Smartscript pharmacy computer systems to provide additional information for pharmacists to counsel patients and to enable medicines management.

For more information:

www.boots-plc.com

... while CEO could double salary in incentive scheme

Boots's new chief executive, former Asda boss Richard Baker, will be able to double his six-figure salary under the terms of the company's new short-term bonus scheme.

Last year, outgoing Boots boss, Steve Russell, earned a basic salary of £600,000, plus £259,000 in bonuses and other benefits.

The terms of the new bonus scheme increase from 60 to 100 per cent of salary, with the bonus payable for achieving operational efficiencies and profitable growth against what the 2003 annual report describes as challenging but achievable forecasts.

During 2002-2003, the performance criteria were profit after tax and sales growth. In 2003-2004, one third of the available bonus will depend on individual performance against personal targets, and two thirds upon sales, profit and return on capital targets.

Boots's total pay bill for 2003 was £5.4 million, up nearly 60 per cent on the previous year. This includes a £2.1m golden handshake for marketing director Barry Clare, who quit in January as part of a senior staff reshuffle. Steve Russell will receive £757,000 compensation for loss of office, plus a £7m pension pot when he leaves the company's payroll at the end of this month.

The vast majority of people regard top companies' directors as untrustworthy and overpaid, a MORI poll has revealed. Four out of five people believe directors of large companies cannot be trusted to tell the truth, while nearly the same number believe they are overpaid.

For more information:

www.boots-plc.com

Pfizer Consumer Healthcare launched

Pfizer has now officially launched Pfizer Consumer Healthcare, the result of the merger between Pfizer and Pharmacia.

At a reception in London last week, Andy Rush, vice-president for UK, Ireland and CEER, said: "We have combined the unique strengths of both companies to create a company that is more than a sum of its parts. Working in partnership with the pharmacy sector we intend to drive self-care by providing a steady stream of innovative products to care for consumers throughout their lives."

Marketing director Carlton Lawson added: "We will be investing heavily in promoting our products, using our considerable marketing and creative expertise to drive consumers into the pharmacy, stimulating category growth and pharmacy sales."

With the addition of Nicorette, Colpermin and Regaine from Pharmacia, Pfizer Consumer Healthcare has a leading presence in IBS, hair loss and the smoking cessation sectors, and markets 10 of the top pharmacy bestsellers, including Benylin, Benadryl, Listerine and TCP.

The combination of Pfizer and Pharmacia means that Pfizer Consumer Healthcare has a huge portfolio of bestselling pharmacy remedies

VMS limits will happen despite opposition

Legislation limiting the number of food supplements that can be marketed in the UK is to come into force anyway, despite the House of Lords voting against it.

The new rules are laid out in The Food Supplements (England) and The Food Supplements (Northern Ireland) Regulations 2003 and list 13 vitamins and 15 minerals, as well as their acceptable forms that can be sold in England and Northern Ireland after August 1, 2005.

The regulations cover labelling, presentation and advertising, including the requirement that products should not be sold if they contain express or implied mention that a balanced or varied diet cannot generally provide appropriate quantities of nutrients.

The Lords defeated the Government 132 to 79 on the motion, which was proposed by the shadow health minister Earl Howe. This argues that more than 300 nutrients or nutrient sources currently on the British market do not feature on the 'permitted' list, meaning they will have to be reformulated or else removed from the market altogether. Among the affected ingredients are sulphur, silicon and 14 forms of selenium, he says.

Earl Howe has called upon the Government to negotiate an amendment with the European Union Commission permitting individual member states to allow food supplements to be marketed, provided they are recognised by the competent authority as safe and appropriately labelled.

However, health minister Lord Warner said that once a directive has been agreed, the Government is obliged to implement it. In England and Northern Ireland, the EU Food Supplements Directive will be enacted via Statutory Instrument 2003: 1387 and Statutory Rule 2003:273 respectively.

Earl Howe said the current situation "lets down this country and its consumers very badly".

The Health Food Manufacturers Association has criticised the legislation on the grounds that it restricts consumer choice.

One out of two internet chemists break the law

Over half of online 'chemists' are illegally supplying prescription medicines, Dundee trading standards has revealed.

Almost all are also breaking consumer protection laws, designed to allow consumers to shop on the internet with confidence, an undercover investigation has shown.

In a link-up with the Medicines and Healthcare products Regulatory Agency, the Scottish trading standards officers assumed a false name and address and attempted to buy Viagra from around 140 online chemists, owned in total by 76 companies. Of these, 61 were UK-based and 12 by EU-registered companies.

Many were already under investigation by the MHRA for suspected breaches of the Medicines Act but were also considered to contravene Distance Selling and E-Commerce Regulations, which provide for fair terms of sale.

According to Dundee team trading standards manager Ken Daly, officers found that only one of the 76 companies investigated complied with the consumer protection rules, and over half the companies were in breach of the Medicines Act. The Medicines Control Agency, which is now part of the MHRA, reports that there have already been five successful prosecutions and that 21 internet sites are currently under investigation. Over 150 more sites have been earmarked for enforcement action, it has said.

In its recent report to the House of Commons Committee of Public Accounts (*C&D, June 28, p8*) the MCA reports that anti-obesity drug Xenical heads the internet medicines' top 10, followed by Proscar for prostate disorders, Propecia for hair loss, Viagra and Uprima for erectile dysfunction, the appetite suppressant Reductil, smoking cessation treatment Zyban, Relenza for influenza and Phentermine and Meridia for obesity. Commenting on the findings, which have been collated in the *Chemist dot com* report, Mr Daly said: "Medicines are very easy to get hold off, both illegally over the internet and from smuggled in sources. Medicines are a very big problem."

New MD for Numark Trading

Simon Colebeck: he has "the ideal experience"

Numark Trading Ltd, the 50:50 joint venture between Phoenix Medical Supplies and Numark plc, has appointed Simon Colebeck as managing director, in a new position introduced to drive the company's plans for future growth.

David Wood, director of NTL and chief executive of Numark plc, said: "Thanks to the hard work of the team NTL is a successful and smooth running operation, but now we need to focus more closely on customers and markets in order to build on our current position. Simon has the ideal experience in this area."

Mr Colebeck has previously held positions with SmithKline Beecham and latterly Crookes Healthcare, where he was sales director. He joins NTL in September.

Online ordering for hospital pharmacists

PharmiWeb Solutions has launched *HospitalPharma.com* to enable hospital pharmacies to order supplies directly from manufacturers.

Hospital pharmacists can view price and prescribing information and place orders through their PC via a standard internet browser. *HospitalPharma.com* uses Microsoft's Windows 2003 Server and the .NET development platform.

David Samways, NHS regional procurement specialist for the South West, said: "We see major benefits in bringing product and company information from a wide variety of pharmaceutical suppliers together online into one single source. This leads to a more convenient way for pharmaceutical suppliers and the hospital-based healthcare professional to work together and will help facilitate some of the initiatives that these parties are currently putting together."

PharmiWeb wrote the specifications for *HospitalPharma.com* after a series of workshops and discussions with its customers. During these they found that pharmacists were wasting a great deal of time going through many sites, in addition to offline sources, to find the information needed to make buying decisions.

HospitalPharma.com now gives them all they need through one interface, including full information on variety of drugs, and also lets them download material such as white papers and articles.

For more information:
Tel: 01344 667430.

GW sets £20 million fundraising target

Cannabis extract pioneer GW is hoping to raise approximately £20 million through a placing for cash of 9,904,395 new GW ordinary shares at 200p per share.

The proceeds of the placing will help to bring forward Phase 3 clinical trials of additional cannabinoid products for new therapeutic markets and to accelerate the development of GW's Advanced Dispensing System for secure drug delivery in the treatment of drug addiction.

The fundraising is in addition to the £5m already received under the recent agreement with Bayer, with these funds applied to the launch of its Sativex multiple sclerosis analgesic in the UK, to secure international regulatory approvals and build the brand.

Dr Geoffrey Guy, executive chairman of GW, said: "Our research findings and the clinical data we have gathered to date have confirmed our early belief in the enormous potential of cannabis-based medicines.

"The placing proceeds will enable us to accelerate the development of additional income streams arising from our core skills in phyto-medicines and secure dispensing technology. The placing also widens GW's institutional shareholder base, providing a shareholder structure more appropriate for the next phase of the company's growth. We have considerable ambitions for the company's development and this fundraising will enable GW to further its plans to move into the top tier of the UK biopharmaceuticals sector."

For more information:
www.gwpharm.com

Advance Information

SEPTEMBER 8-9
SMI's Pharmaceutical Stability Testing Conference
The Hatton, London. Details tel: 020 7827 6412.

SEPTEMBER 23
UKCPA Quality & Risk Management group study day
Are patients any safer? How well are risk reduction strategies working? at Midland Hotel, Derby. For details contact Pat Kennedy, administrative assistant: tel: 0116 277 6999.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Deep penetrating relief
New!
Strengthens Teeth
AND
Helps Protect Gums
Teeth & Gum Defence
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nicorette
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nicotine
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lasts 8 hours
avoids drowsiness
24 CAPSULES

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It all sounds like the ideal prescription for a healthy and promising future.

Pfizer

Consumer Healthcare

Comment from the Editor

The first details of the proposed new pharmacy contract for England and Wales are now out in the open. PSNC should be commended for attempting to make sure the consultation is as inclusive as possible. And the promise that it will ultimately be the contractors who decide whether to accept the contract (fingers crossed there's no DoH imposition) gives even more incentive for all community pharmacists, whether contractor or employee, to help inform what this contract should look like.

The fact that money cannot be apportioned yet to the contract makes it difficult for some to evaluate the basic framework, but at this stage PSNC is merely asking whether this framework is the sort of thing contractors want or whether some other plan is needed – as would be necessary if control of entry regulations are abandoned.

Judging from the reaction at the first roadshow, there was no outright rejection of this plan; rather, the first response was what would the new contract mean for individuals? This promises to be a significant paradigm shift.

PSNC did not really get an answer to its question of whether it was on the right track. Roadshow attendees also failed to ask whether the cost of service survey results would be accepted by the DoH – so far it has only agreed that a survey should take place. Similarly, the issue of out of hours or oxygen services, or the outcome of the generics inquiry were not raised at this first meeting, pharmacists attending other roadshows have that opportunity, or can send their view in to PSNC via post or e-mail.

However, by being as transparent as is practicable and without giving too much strategy away to the Government, PSNC will give more ownership to pharmacists. That's something another pharmacy organisation should have considered from the outset, although its modernisation process may be too far down the road to win friends now.

PSNC did not really get an answer to its questions as to whether it was on the right track

Yourviews

Ple@se e-mail your views to chemdrug@cmpinfomation.com

Response on the RPSGB Charter roadshows

Last week's edition of *C&D* questioned whether the Society will generate sufficient feedback from its consultation on the proposed draft Royal Charter.

This report (*C&D June 28, p6*) was based on attendance figures for the 'Fit for the future' Charter roadshows which have been seen by over 250 pharmacists. However, what you didn't report was the fact that around 700 pharmacists have also attended branch meetings on this same issue.

As part of its Charter consultation the Society has looked to give pharmacists in England, Scotland and Wales the opportunity to debate the issues face to face with members of Council and senior Society staff. It was realised from the outset that not all members would be able to attend a regional meeting and

Andrew Burr: not all members would be able to attend

therefore the Council agreed for funding to be made available for branches to hold local meetings. As a result of the regional roadshows, branch meetings and the presentations given at May's AGM and the branch representatives' meeting, well over 1,000 pharmacists will have been directly engaged in the debate.

Clearly, meetings of this nature will never attract the entire membership and therefore form only one part of the consultation process. The Society has also looked to engage the membership through the pharmacy media and this week's *Pharmaceutical Journal* includes a further detailed report on the draft Charter and a feedback form to gauge members' views. In addition, pharmacists can also feed back their views via the Society's website *www.rpsgb.org.uk*

The draft Royal Charter will play an important role in helping to shape the future of our profession and I would encourage the membership to get involved in the consultation process.

Andrew Burr
member of the RPSGB Council.

Editor's note:
The article, which was about the l of attendance at the Society's Charter roadshows, clearly stated that 48 branches had applied for funding to host the roadshows and that sufficient funding was availa for 80 such meetings.

Unfortunately, although the Society was able to provide figure attendance at the Charter roadshows, it said it could not tell how many people had at that stag submitted written responses as the consultation was ongoing. This w figure we would have liked to hav included for the sake of balance.

Mr Burr makes no mention in the response of the 330 plus people who attended the Special General Meeting on June 1.

HOSPITAL REPORT

Priorities for the members

There has been talk of little else in the hospital pharmacy department. The ins and outs of the proposed new RPSGB Charter have been the main topic of discussion for several weeks.

Alright – that's a lie. Although the RPSGB might wish that reasoned discussion and debate is the order of the day wherever two or more pharmacists get together, the truth is that I have not heard anyone mention it, never mind discuss it. The Society is not getting the message through to the majority of its membership, to whom the Charter means little, if anything at all. The politics of the Society bore them rigid. The *Pharmaceutical Journal* drops through the letterbox each week, but the jobs and possibly the CPD sections are the only ones ever perused – if the *PJ* is removed from it's wrapper at all! With a few exceptions, the younger members of the profession have grown up with a deep distaste for politics

Younger members have grown up with a deep distaste for politics and most politicians

and most politicians. This has extended to include intra- and inter-professional politics.

However, the Charter issue is important. The RPSGB wishes to bring itself up to date, but has failed in at least one major area. The Scottish department must be enshrined within the Charter.

The woolly phrasing shows Lambeth still refuses to recognise devolution. Scotland's Parliament is responsible for health policy, not Westminster. The NHS in Scotland will soon look very different from the NHS in England. Failure to recognise this could reduce the relevance and effectiveness of the RPSiS, and this must not happen. Ignore it at your peril.

Written by a practising senior hospital pharmacist

TOPICAL REFLECTIONS

Waiting for Godot? No, just the OFT

The build up to the Parliamentary summer recess is excruciating as the Government's response to the Office of Fair Trading report into contract limitation is crucial to the whole future development of not just my pharmacy but to the direction of my future livelihood. But as in all things politic the response will be taken to the line and even then may be delayed because of unforeseen circumstances!

Then there will be the period of consultation, even though by now any minister worth their salt will be intimately aware of the reaction by pharmacists to most proposals. Why the Government has prevaricated is still unclear but what is certain is that the satisfactory implementation of a new contract and associated new services cannot be implemented efficiently by April 2004; there is just not enough time.

Certainly Sue Sharpe, PSNC chief executive, is of the opinion that April 2004 is over optimistic (*C&D June 28, p5*) and is looking to the autumn before any degree of clarity can be discerned.

But I would like some information now so I will be going to a PSNC roadshow at the earliest opportunity. With what I am able to glean at that meeting coupled with the Government's promised announcement by July 17 I should have a better idea how to plan the future development of my business. It will still all be hypothesis because that vital component, money, will still be missing.

But I cannot sit on the fence forever. As a business plan to be presented to my friend in the cupboard it will stink but at the moment it is the best I can hope for!

Finding the resources for extracurricular activity

I am not surprised that so few pharmacists have felt the need to attend a Royal Pharmaceutical Society roadshow on the new Charter proposals. I am suffering from a severe dose of political overload and have to prioritise the little time I have left after a full day working for the NHS. My priority is to my financial future, so contract problems come first, then the RPSGB modernisation proposals are considered and finally the proposed new Charter. It really is just too much for this elderly brain to digest and to constructively comment on all at the same time.

My preference would have been for a special local branch meeting to be organised and my local Council member to have then led an informed debate on both the modernisation and Charter proposals. But I now realise that I am in a branch that feels financially unable to assume the burden for such a debate and there is the insult of insufficient Lambeth funding to enable it to do so.

I am left with the alternative of talking privately to colleagues and then making my opinions known on a feedback form. A most unsatisfactory last resort to a consultation process that should have been fully funded by Lambeth to have been properly conducted through organised meetings at local level.

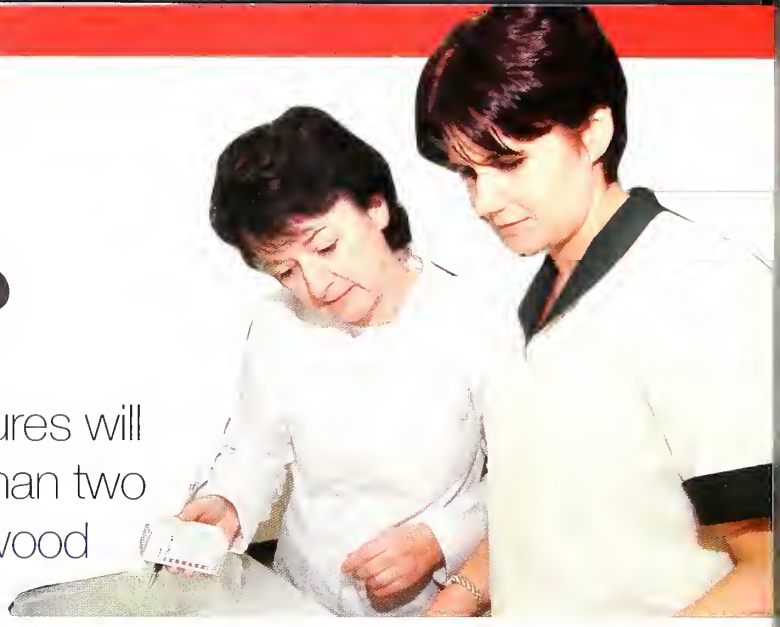
Power to the PSNC

Sue Sharpe, PSNC chief executive, says that she would be taking a low-key approach to the potential problems of primary care trusts becoming involved in direst supply arrangements for either drugs or dressings, thereby interfering with the accepted role of community pharmacies in the distribution of medical products (*C&D June 28, p4*).

In support of this policy she then says that PSNC will be warning all PCTs that they do not have the legal power to enter into direct buying arrangements and that PSNC will seek judicial review against any PCT that does decide to direct buy.

I fully support PSNC. Full distribution of all necessary medical products through pharmacy is essential to ensure proper continuity of patient care. Fragmentation of that system puts pharmaceutical care at risk and must be resisted. I am all in favour of a judicial review against any PCT not taking PSNC's advice and if necessary defending this major plank of the community pharmacist's role against any threat to change the law. But I would hardly call that approach low-key!

Do they mean me?



Yes, standard operating procedures will apply to all pharmacists in less than two years' time, says Vanessa Sherwood

You've been dispensing for years, the system runs well and your experienced staff know what they're doing. Then you hear something about standard operating procedures. Do these really apply to you? Are you really going to have to write instructions for every procedure, like taking in and giving out prescriptions, and simple dispensing? Surely this is just for the multiples?

Well, no, it isn't. The RPSGB has said that, from January 2005, there will be a requirement for pharmacists to put in place and operate written standard operating procedures covering the dispensing process, including the transfer of prescribed items to patients. This will apply to both hospital and community pharmacies.

The RPSGB says an SOP should simply "specify in writing what should be done, when, where and by whom". It says that the benefits of SOPs include:

- helping to assure the quality and consistency of the service
- helping to ensure that good practice is achieved at all times
- providing advice and guidance to locums and part-time staff.

Boots The Chemists is already working on SOPs for its pharmacies. Despite having formal procedures in place for all dispensing processes the development of simple templates for SOPs is one of its key priorities in the area of clinical governance.

Stephen Eastham, head of clinical governance for the company, believes SOPs are a fundamental part of risk management. "Our vision is to adopt this simple template as current operating procedures are reviewed and updated," he says.

Although the RPSGB has said that the pharmacist in charge is responsible for SOPs, Boots does not expect its pharmacists to be writing their own SOPs. The company's plan is that pharmacists in store join in at the "implement and review where appropriate" stage.

"Some local tailoring may be needed and any changes from the corporate SOP will have to be recorded locally by annotating the SOP. In reality we envisage that the corporate SOP will apply to the majority of circumstances found in Boots," he says.

"We know how to dispense – why do we need to write it down?" is a question Mr Eastham's been asked over and over again. "We need SOPs to increase patient safety and the level of consistency of patient experience," he explains.

Common myths about SOPs are that they: add complexity; add cost; are unnecessary. This year's clinical governance roadshows for Boots dispensary staff and pharmacists included an interactive workshop on SOPs, designed to dispel some of these myths.

Boots says that as the changes would affect dispensing staff, not just pharmacists, it was important to involve them in SOPs as early as possible. Participants were given a 'dispensing kit' and asked to assemble a prescription for a monitored dosage system in a limited period of time. The participants were marked on accuracy, teamwork and procedure.

In the second stage, each group had to write an SOP for the process they had just performed. In the third and final step, the SOP was used by a neighbouring group to perform the process again, with much better results. Mr Eastham says this exercise demonstrated that SOPs help to:

- identify key roles
- develop a methodological approach
- give a clear understanding of individual responsibilities

Top SOP tips*

- Keep it simple – the fewer stages in the process the better.
- Keep to action-orientated, simple statements.
- Use SMART (specific, measurable, achievable, relevant and timed) principles to describe each step and focus on what needs to be done.
- Avoid adding any supplementary information but you can refer to other documents - this is an action orientated document, not a reference manual.
- Assign responsibility appropriately, eg if the process can be done by a pharmacy assistant make them responsible.
- Go back and simplify further after discussing your first attempt with a colleague.
- Use someone unfamiliar with the process to check the SOP. If they can understand it and complete the task then it is probably a good example.

**Courtesy of Boots*

- help to understand where decisions need to be made and provide a process for managing those decisions.

"It demonstrates that SOPs can make a difference," he says. He believes that the Boots SOP is unique in including a section on the risks associated with not carrying out a stage in the procedure. This identifies the problems that could arise if the action is not taken. Staff can clearly see the consequences of not following the SOP.

There is also an audit section on the template so the pharmacist can check how often each step is used. This is divided into three sections: always, sometimes and never. "If a stage in the SOP is never used it doesn't necessarily mean that's wrong. It may be that the pharmacist has found a better way of doing things," says Mr Eastham. Each section on the audit is awarded points. The pharmacist can then quickly audit the form by marking the frequency with which the stage is used and scoring the process.

Although SOPs are important professionally, Mr Eastham also makes a business case for them. He says SOPs provide:

- a better patient experience
- easier training
- clear definition of staff roles and responsibilities
- easy to access information
- an integral audit tool
- increased efficiency, consistency and compliance.

"A better patient experience is a driver for success as it increases loyalty," says Mr Eastham. This is particularly important because, with the advent of repeat dispensing, pharmacies have the opportunity to acquire at least six months' worth of dispensing for one patient at a time.

Boots expects to have about 100 pharmacies taking part in the Department of Health's first repeat dispensing pilots. Sharon Giles, Boots's project manager for dispensing, marketing and operations, says: "I was really surprised how quick and easy it was to write SOPs from scratch – much quicker than the formats we have used in the past. The real key was keeping each statement as short and simple as possible, and then trying to simplify it even further."

SOPs can't be all that bad. Mr Eastham describes them as "addictive, fun and exciting". Perhaps you should try it.

In her second article to coincide with Alzheimer's Awareness Week (July 6-12), *Mary Allen* FRPharmS looks at drug treatments

Drugs in Alzheimer's

THE COLLEGE OF PHARMACY PRACTICE
This course (module 1275), in association with multiple choice questions being published in C&D August 2, provides one hour's continuing education

Objectives

- To understand the pathophysiology of AD
- To understand how drug treatments are thought to work
- To understand the benefits and drawbacks
- To be aware of NICE guidelines
- To be aware of how pharmacists can support carers

Until recently, there was no drug treatment specifically for Alzheimer's disease (AD). The best on offer, after excluding and treating any other causes of real or perceived dementia, was control of unwanted symptoms, which generally included the use of antidepressants, antipsychotics and anxiolytics.

Symptom management is still a feature of therapy, but there is evidence that the introduction of newer, more specific drugs for AD slows down disease progress. This means early and accurate diagnosis is essential if patients are to benefit from treatment, and to ensure that drugs are appropriately prescribed. Drugs useful in mild to moderate AD are ineffective in the treatment of some other dementias such as Pick's disease, and may actually worsen symptoms.

Current therapy

New drug treatments are coming from discoveries about the disease itself. It is now generally agreed that transmission at most, if not all, synapses is mediated by chemical neurotransmitters, released by action potentials passing down nerve axons, which then act on the post-synaptic cell body, increasing ionic permeability and propagating a further action potential.

Systematic biopsy and autopsy studies in AD have confirmed the existence of neurotransmitter deficits, in particular acetylcholine (ACh). Studies in the 1970s and 1980s indicated that a substantial pre-synaptic cholinergic deficit occurs in AD patients, which is thought to have many causes. In addition, animal studies established an emerging role of ACh in learning and memory. This resulted in a hypothesis proposing that degeneration of cholinergic neurones and associated loss of cholinergic neurotransmission contributed significantly to the cognitive decline seen in AD.

This meant that pharmacological intervention could potentially help as, in theory, drugs that increased brain ACh levels should therefore be of benefit. Treatment strategies could include drugs which:

- increased the levels of ACh directly through increased synthesis and release
- acted as direct agonists
- reduced its metabolism by inhibiting acetylcholinesterase.

The cholinergic hypothesis has been challenged over the 20 or so years since its proposal. However, current thinking suggests that there is also a glutamatergic neurotransmission factor in AD, which accounts for some of the perceived shortfalls in the

Diagrammatic representation of a nerve synapse showing vesicles in the first nerve responding to electric stimulus and releasing neurotransmitters. These travel across the synapse and bind to receptors on the second nerve. A reduction in the neurotransmitter acetychlorine is thought to have a role in Alzheimer's disease

Continued on page 18

cholinergic hypothesis, and provides the potential for other routes for drug intervention (*see memantine, below*).

Attempts so far to boost ACh levels in the brain, or to develop direct agonists, have proved unsuccessful. Trials using lecithin and choline, both precursors of ACh, have failed to show increased levels of central cholinergic activity, and the development of post-synaptic cholinergic receptor agonists have shown unacceptable adverse effects. Research has therefore focused on cholinesterase inhibitors.

The first of these, tacrine, showed improved cognitive impairment in some patients but has not been used in the UK because of its associated liver problems. Three other drugs have subsequently been marketed in the UK, licensed for mild to moderate dementia in AD. These are donepezil (Aricept), rivastigmine (Exelon) and galantamine (Reminyl).

All three inhibit acetylcholinesterase. Galantamine, originally derived from snowdrops and daffodils, also enhances the action of acetylcholine on nicotinic receptors. Nicotinic receptors are concentrated in the brain, spinal cord and muscles, and appear to be involved in cognition, pain and neurodegeneration. A growing body of evidence suggests that drugs that regulate specific nicotinic receptors may be used to treat a number of disorders including Alzheimer's disease, Parkinson's disease and schizophrenia.

The new drugs should be initiated by specialists, using dose titration to reduce side effects and maximise effectiveness.

Clinical effectiveness

The National Institute for Clinical Excellence produced guidance in January 2001 indicating that donepezil, rivastigmine and galantamine should be available on NHS prescription for appropriate patients with mild to moderate AD (*see box for a summary*).

NICE intends to issue reviewed guidance in December 2003 and has called for further evidence to identify:

- whether the three drugs are of similar effectiveness
- whether their effect establishes itself immediately and then declines, or whether they have a cumulative effect over time and influence the course of the disease
- the extent of adverse effects over time, particularly in relation to dosage
- and to identify the place of the drugs in:
- severe dementia
- the management of non-cognitive symptoms and behavioural disturbance in dementia
- whether the drugs are of benefit in other forms of dementia.

The guidance indicates that (at the time it was published), it is uncertain whether patients who come off the drugs decline to the level they would have been without the drug or decline even further. Neither does anyone know for sure how the drugs will affect delays in institutionalisation. Currently, their cost-effectiveness depends in part on this factor, and NICE has requested more precise data.

Cholinesterase inhibitors antagonise the effects of antimuscarinic (anticholinergic) drugs such as tolterodine and oxybutinin.

Glutamate antagonists

Memantine (Ebixa) is the first glutamate antagonist drug to be used in AD, licensed last year for use in the middle and later stages of Alzheimer's disease, slowing down the progression of symptoms. There are suggestions that it may slow down the disease process itself. Its action is complex, especially when compared with the three existing treatments.

Although the process is not yet fully understood, it is now thought that a wide variety of acute and chronic neurological disease may be mediated, at least in part, by a final common pathway of neuronal injury involving excessive stimulation of glutamate receptors. In relation to AD, there is increasing evidence that malfunctioning of glutamatergic neurotransmission, in particular at NMDA-receptors (N-methyl-D-aspartate), contributes both to expression of symptoms and disease progression in neurodegenerative dementia.

The processes of learning and use of memory are thought to involve the release of high levels of glutamate, which affects neuroreceptors by removing a magnesium "cover", increasing cell permeability to calcium ions and thus propagating the action potential.

In AD patients, brain cell glutamate levels are thought to be high even when the cell is at rest. This results in the neuroreceptor magnesium cover being permanently "off", allowing calcium ions to flood into the cell, adversely affecting the transmission process.

Memantine antagonises the action of glutamate, effectively replacing magnesium as the cover for the neuroreceptors. Unlike magnesium, memantine is not removed from the neuroreceptor by the raised levels of glutamate present when cells are at rest.

However, when a learning or memory event occurs, the glutamate level rises enough to dislodge the memantine, increasing cell permeability to calcium and propagating the action potential.

There are suggestions that the build up of calcium in the cell may itself contribute to premature cell death. Dying cells release glutamate in even greater amounts, and so the process of cell dysfunction and death is accelerated. For this reason, memantine is thought to protect cells from excess calcium damage thus slowing down the progress of the disease. In contrast, the cholinesterase inhibitors are not thought to affect the disease process, and merely slow down the progression of symptoms.

A small study (*N Engl J Med 2003;348, 14: 1333-1341*) published recently suggests that memantine may slow mental and physical decline by about six months. The study reports results in 252 patients with moderate to severe AD from 32 US centres. The patients lived in the community with care provided by family members. The patients were losing the ability to dress themselves, bathe, use the toilet, clean themselves and remain continent. The condition of the patients declined about half as much as those taking placebo over six months. As well as showing significantly less deterioration, these patients needed less time from caregivers.

NICE guidelines for the use of cholinesterase inhibitors, January 2001

NICE recommended that donepezil, rivastigmine and galantamine should be made available within the NHS as one part of the management of some people with mild and moderate Alzheimer's disease. Patients should be examined using the mini mental state examination (MMSE) and, if they score 12 points or above, these drugs should be available in the following circumstances:

- diagnosis of AD must be made by in a specialist clinic, along with an assessment of cognitive, global and behavioural functioning, activities of daily living and the likelihood of compliance with treatment
- treatment should be initiated only by a specialist, but can be continued by GPs under a shared care protocol
- carers' views about the condition should be sought before and during treatment
- assessment should be repeated usually two to four months after the maintenance dose is established and treatment should be continued only if the MMSE score has improved or not deteriorated, together with improvements in behaviour and/or functioning
- patients who continue on the drug should be reviewed every six months. The drug should only be continued where MMSE score remains above 12 points and if other tests show that the drug is having a worthwhile effect.

Reviewed guidance is expected in December 2003

Side effects of cholinesterase inhibitors

The most frequent side effects include:

- nausea and vomiting
- diarrhoea
- stomach cramps
- headaches
- dizziness
- fatigue
- insomnia
- loss of appetite.

Side effects of memantine

The manufacturers report a low incidence of side effects, usually mild to moderate in severity, which include:

- hallucinations
- confusion
- dizziness
- headaches
- tiredness.

How pharmacists can help

- Review medication and discuss with GP, aim to discontinue unnecessary drugs.
- Provide medicines in Dosett boxes or MDS, but only where appropriate.
- Remember that the patient may not have been complying with medicines prior to receiving a Dosett box, so doses of other medicines may need adjusting.
- Remember that drugs with anticholinergic side effects (such as antidepressants, antipsychotics, oxybutinin, tolterodine) may affect symptoms or disease.
- Simplify drug regimes, aiming for once or twice daily administration. Drugs which are simple to take, such as calcium and vitamin D, may be better than bisphosphonates for osteoporosis.
- Remind carers to check, when they buy OTC medicines, if the medicine is safe.
- Remember that frail elderly people may need smaller doses because of hepatic or renal impairment.
- Encourage carers to return all unwanted medicines for destruction.
- Explain to carers what each drug is for, and, for newly prescribed drugs, what any likely side effects might be.
- Look out for any drugs that may cause confusion, such as digoxin.
- Remember that carers carry a heavy load. Try to provide a sympathetic environment.
- The Alzheimer's Society provides excellent information sheets on its website: *www.alzheimers.org.uk*

Memantine was not associated with a significant frequency of adverse effects.

NICE guidance on the use of memantine is expected soon. In the meantime, the Faculty for the Psychiatry of Old Age has issued interim guidance on its use, for certain cases, but recommends that cholinesterase inhibitors remain the treatment of choice. The recommended dose is 5mg daily during the first week, increasing by 5mg daily to a recommended dose of 10mg twice daily.

Memantine should not be used with other N-methyl-D-aspartate (NMDA)-antagonists such as amantadine, ketamine or dextromethorphan.

Other drugs

Non-cognitive behavioural changes – including depression, aggressive behaviour, psychosis and over-activity – often start after the onset of cognitive symptoms, usually in conjunction with marked cognitive decline. These changes generally increase with severity of dementia. The symptoms are often difficult to manage, and are a common cause of distress for carers and a major trigger for long term care admission.

Before the introduction of the newer treatments outlined above, all that was available was control of unwanted symptoms, and this remains the line of action for those patients who do not respond to cholinesterase inhibitors or for whom these drugs are inappropriate. This generally includes the use of antidepressants, antipsychotics and anxiolytics.

- Particular symptoms likely to respond to antidepressants are early morning insomnia, poor appetite, and lack of energy.
- Antipsychotic drugs may help symptoms such as delusions, hallucinations, hostility and agitation or hyperactivity but are unlikely to help other symptoms such as social withdrawal or confusion.
- Benzodiazepines may have limited use in treating symptoms such as panic reactions or excessive nervousness.

Use of these medicines is not without problems in patients who are both elderly and cognitively impaired. Side effects and problems such as confusion and increased risk of falls may increase the deterioration of the patient. None of the medicines improves cognitive function, and may affect it further. There is little evidence to support the use of conventional antipsychotics. Their anticholinergic side effects may contribute to confusion and progression of cognitive impairment and use should be limited to patients with serious problems such as psychosis or serious distress. Other drugs with anticholinergic activity, such as oxybutinin and tolterodine, may also cause problems in AD patients.

Trazodone is well established in clinical practice in the UK and is often used first line to treat behavioural problems, avoiding the side effects associated with antipsychotics. Although only specifically licensed for depression, it is also useful for symptoms of agitation and aggression.

This client group and their carers need a lot of support with medication issues. Suggestions for pharmaceutical care are included in the box. The introduction of the newer drugs also means that pharmacists may become involved in supporting patients and carers earlier in the disease process than they have previously been.

Mary Allen is a part-time community pharmacist and hospice pharmacist in Herts.

The introduction of the newer drugs means that pharmacists may become involved in supporting patients and carers earlier in the disease process than they have previously

Actionplan

1. Using reference sources try to find out more about brain neurotransmission. Pay particular attention to cognitive features of behaviour.

2. Are any of your Alzheimer's patients taking acetylcholinesterase inhibitors? Ask them/their carers whether they noted any improvement with these drugs. Although these reports will be anecdotal, do you and/or the patients/carers think they are cost effective?

3. Do you still dispense these drugs on private prescriptions? If so, can you find out if it is because the patient's NHS doctor has "refused" to prescribe them. Is the refusal the result of the patient not meeting the NICE guidelines?

4. Do you have any patients taking memantine? Try to get feedback on its effects.

5. Apply the suggestions in "How the pharmacist can help" opposite, to one of your known Alzheimer's patients. Did this exercise result in any changes? Is it worthwhile to extend it to all patients?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are invited to test their knowledge by using the multiple choice question (MCQ) paper to be inserted in the August 2 issue, which will offer the same CPD accredited modules together with those in the July 19 and 26 issues. These will cover:

- **Alzheimer's part 2 (1275)**
- **Medicines management in the elderly (1276)**
- **Systemic cortcosteroid therapy (1277).**

A telephone marking service offers independent verification of results – details on the monthly MCQ paper. People wanting to register for Pharmacy Update can contact Mary Preble on 01732 377269.

C&D in association with GP GENUS PHARMACEUTICALS

Polypill could reduce heart disease by 80pc

A single daily combination tablet has been proposed that could reduce incidence of cardiovaseular disease by over 80 per cent.

Widespread use of the "Polypill" would have, "a greater impact on the prevention of disease in the Western world than any other single intervention", the originators of the concept claim in the *BMJ*. The Polypill could largely prevent heart attacks and stroke if taken by everyone aged 55 and older and everyone with existing cardiovascular disease, while being acceptably safe.

The formulation would contain:

- a statin (eg atorvastatin 10mg daily or simvastatin 40mg)
- three blood pressure lowering drugs (eg a thiazide, a beta blocker and an ACE inhibitor), each at half standard dose
- folic acid 0.8mg
- aspirin 75mg.

Analysis of over 750 trials found that the Polypill reduced ischaemic heart disease (IHD) events by 88 per cent and stroke by 80 per cent. A third of those aged 55 and older would benefit, gaining an average of 11 years of life free from IHD or stroke. Only one or two people per 100 would experience side effects warranting withdrawal and fatal side effects would occur in less than one in 10,000 users.

The Polypill simultaneously reduces four risk factors: low density lipoprotein cholesterol, serum homocysteine, blood pressure and platelet function.

A series of papers and supporting editorial have been published in what its editor described as "the most important *BMJ* for 50 years". All the Polypill's ingredients will shortly be off patent and it could be cheaply produced and made widely available.

For more information:

BMJ, 2003; 326: 1419-1423
www.bmj.com

Over 50s cholesterol tests

Measuring cholesterol levels in everyone over 50 is a simple and efficient method of identifying those at high risk of coronary disease among the general population, according to a study in the *BMJ*.

It found that current guidelines fail to identify 20 per cent of patients who may benefit from treatment for heart disease. It compared national service framework criteria, Sheffield tables, estimated risk assessment using fixed cholesterol levels and an age threshold of 50 to identify people with a 10-year coronary risk of 15 per cent or more.

An age threshold of 50 years selected 46.3 per cent of people for cholesterol measurement and identified 92.8 per cent of those at 15 per cent or more risk.

The other three methods selected between 17.8 per cent and 73.1 per cent for measurement and identified between 75.9 and 99.9 per cent of those at 15 per cent or greater risk.

For more information:

BMJ 2003, 326: 1436
www.bmj.com

Difficulty quitting smokin is in the genes

Difficulty in stopping smoking could be linked to a gene that also protects against pulmonary emphysema.

A study in *Thorax* compared the genotypes of current and ex-smokers with non-smokers. It found a link between the CYP2A6 gene (which is responsible for nicotine metabolism and has several different polymorphisms), smoking habit and pulmonary emphysema.

Twice as many current smokers (40 per cent) possessed the CYP2A6del (genotype D) allel than ex-smokers. Subjects with the CYP2A6del allele also tend not to be heavy smokers, but w light habitual smokers.

The authors of the study conclude that this will help to identify those who would benefit most from NRT and will give a new insight into the pathogenesis of smoking-indu emphysema.

For more information:

Thorax 2003; 58:623-628
www.thoraxjnl.com

Scriptlines

Etodolac capsules

Viatris Pharmaceuticals has launched Eccoxolac (etodolac) 300mg capsules. Eccoxolac is licensed for acute or long term use in osteoarthritis and rheumatoid arthritis. The dose is 600mg daily or 300mg twice daily.

Price: £8.75

Pack size: 60 capsules
PIP code: 294-4437
Viatris Pharmaceuticals Ltd
Tel: 01233 205999.

Zirtek 200ml POM to P switch

Zirtek solution 200ml has been switched from POM to P. It will be known as Zirtek Allergy Solution. RRP is £17.55. Pip code and NHS price are unchanged.

For more information:

UCB Pharma Ltd
Tel: 01923 211811.

Two new foods from Nutricia

Nutricia is launching Fortisip Protein and Nutrison Vitaplus Multi Fibre, which are both ACBS approved foods for special medical purposes. Fortisip Protein is a high protein nutritional supplement available in strawberry, vanilla, forest fruits and chocolate flavours. Nutrison Vitaplus Multi Fibre is a nutritionally complete liquid enteral feed.

Price: Fortisip Protein, £1.54. Nutrison Vitaplus Multi Fibre 500ml, £4.03; 1000ml, £8.05.

Pack size: Fortisip Protein, 200ml tetra. Nutrison Vitaplus Multi Fibre, 500ml glass and 1000ml pack
PIP code: Fortisip Protein - strawberry, 295-9799; vanilla, 295-9773; forest fruits, 295-9807; chocolate, 295-9815
Nutricia Clinical Care
Tel: 01225 768381.

Cafergot SmPC changes

Several changes have been made to the SmPCs for Cafergot suppositories and tablets. These include the additional contra-indication that Cafergot should not be give to patients taking potent CYP 3A4 inhibitors such as macrolide antibiotics and protease inhibitors. This follows links with serious and life-threatening ergotism. Cafergot has also been contraindicated in temporal arteritis.

For more information:

Alliance Pharmaceuticals Ltd
Tel: 01249 466966.

Ketoconazole DT error

Ketoconazole cream 2 per cent was wrongly listed in the June *Drug Tariff* as based on Daktarin Dual Action at 283p. It should be based on Nizoral cream at 381p 30g and has been amended for July *Tariff*. This does not affect reimbursement and contractors be paid 381p for 30g.

Xefo discontinue

CeNeS is discontinuing Xefo (lornoxicam). It expects current stocks to be exhausted in about four months' time.

For more information:

CeNeS Pharmaceuticals
Tel: 01233 266466.

Optilast up to 8m

Viatris is increasing the volume Optilast eye drops from 6ml to 8 Price and Pip code remain the same.

For more information:

Viatris Pharmaceuticals Ltd
Tel: 01223 205999.

Aquafresh makes cleaning teeth child's play

GlaxoSmithKline Consumer Healthcare hopes to encourage children to brush their teeth with a fun kids' battery-operated toothbrush.

Aquafresh Clip-on Friends toothbrushes feature a clip-on character on the front. There is a choice of five characters – Leonard the Lion, Eva the Elephant, Mino the Monkey, Spectrum the Robot and Princess Isabella.

The dual-action brush has an oscillating round head to clean teeth surfaces and a moveable interdental head to clean between the teeth.

Each brush comes complete with one of the Clip-on characters, a pop-on travel cap and a key ring toy. Additional characters can be purchased along

with a replacement head.

Marketing support designed to bring the characters to life will start in the autumn to coincide with the new school term.

Price: £4.99, replacement head £2.49

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Witch takes to the air

The revamped Witch facial skincare range (*C&D June 21, p23*) will be advertised on TV from this month.

Part of a £3 million support programme, the TV campaign will be aired on peak spots for four months.

The new commercial promotes the Witch range as a "gentler way to skin refreshment".

The range is also being supported by a press campaign and a new website at *www.witchskincare.com*

For more information:

E C De Witt & Co Ltd
Tel: 01928 579029.

PoliGrip gets a grip

The PoliGrip range of denture fixatives is being relaunched with a new look.

The metallic packs are designed to reflect the premium positioning of the range, bringing it closer in line with standard oralcare products.

New in the range is PoliGrip Total Care Denture Fixative Cream. It is formulated to provide a strong hold and a barrier to irritating food particles, as well as delivering fresher breath.

It is also claimed to have an anti-bacterial action.

PoliGrip Fresh Gel has been reformulated to offer a stronger hold with improved taste and texture.

Price: all products £3.09 for 40g except PoliGrip Original (£2.99 for 50g)

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Massage gel delivers right to the point of the pain

Vitabiotics is introducing a dual action massage gel into the Jointace range for maintaining healthy joints.

Jointace Gel combines glucosamine and chondroitin with six essential oils including ginger, clove bud and eucalyptus oil.

The manufacturer says the delivery of glucosamine directly at the site of the joints may help to reduce the risk of stress-related damage or injury to the joints as a result of high impact sporting activity such as running.

The gel should be massaged directly into tired joints and muscles as required.

The launch will be supported by a £650,000 marketing campaign including poster, tube and radio advertising.

Price: £7.95

Pack size: 75ml
Pip code: 296-3783
Vitabiotics Ltd
Tel: 020 8902 4455.

Frontshop

Hedex to the rescue

With the school summer holidays almost here, stressed mums are being targeted in a new TV campaign for Hedex.

Three humorous commercials, which are designed to strike a chord with busy mums, will be screened on satellite TV until the end of September. Programming will centre around popular family shows such as *Friends*, *ER* and *Big Brother*.

Each commercial shows a different brand variant – Hedex regular, Hedex Extra and Hedex Ibuprofen – in an effort to raise the profile for the whole range.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Sleep soundly with Pepcidtwo

Pepcidtwo is in the public eye throughout July and August in a TV campaign designed to boost sales over the holiday season. The commercial features a man who gets an attack of heartburn at a party – a situation that many sufferers will easily identify with.

After taking Pepcidtwo he is able to enjoy the party and go home to a peaceful night's sleep.

A booklet and website are now available to sufferers. Customers can order *Sleeping soundly: The essential guide for all heartburn and indigestion sufferers* from *www.sleepingsoundly.co.uk*

For more information:
Johnson & Johnson MSD
Tel: 01494 450778.

Inbrief

Better Solutions

Accantia Health & Beauty is relaunching two products in the Lil-lets Solutions range with improved formulations. Relaxing Rub is designed to soothe aches and cramps and Active Feminine Wipes offer the dual action of gentle cleansing with pH balancing.

For more information:
Accantia Health & Beauty
Tel: 0121 327 4750.

Menopause awareness

Vitabiotics, maker of Menopace tablets, has teamed up with leading women's health charities the Menopause Amarant Trust and WellBeing for the first National Menopause Awareness Month which will take place in August.

For more information:
Vitabiotics Ltd
Tel: 020 8902 4455.

Superhero boost for Milk of Magnesia

Mums with kids who experience upset stomachs are being targeted in summer advertising for Phillips' Milk of Magnesia. A national £150,000 campaign is appearing in women's magazines until September. The advertisements feature two cheeky and healthy kids in superhero outfits with the strapline 'because even superheroes get tummy aches'.

Milk of Magnesia will also be supported with educational activity including consumer leaflets.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Daktarin sponsors top athletic events

Daktarin athlete's foot treatment is sponsoring this year's UK Athletics which will be taking place in Gateshead, Birmingham and Crystal Palace during July and August. Each event will be broadcast on BBC TV.

The brand is also being supported by a press campaign entitled 'Personal best' appearing in men's magazines and the sporting press this summer.

For more information:
J & J.MSD Consumer Pharmaceuticals
Tel: 01494 450778.

TV next week

Accu-Chek Advantage blood glucose meter: C4

Accu-Chek Compact blood glucose meter: C5, GMTV, Sat

Benadryl: All areas except C4, C5, GMTV

Bodyform: U, STV, C, HTV, W, LWT

Canesten Oral: All areas except CTV

Clearasil Complete pore cleansing wipes: All areas except GMTV

Flixonase: All areas except U, CTV, GMTV

Germoloids: All areas except C, A, M, LWT, CAR

Lamisil: All areas except GTV, U, B, CTV, GMTV

Listerine: All areas

Lloydspharmacy Solero Suncare range: All areas except U, LWT, CAR, GMTV

Pepcidtwo: All areas

Piriteze: All areas except U, CTV, GMTV

Pro Plus: C4, C5,

Rennie Soft Chews: All areas

Ribena: All areas except U, CTV, GMTV

Tena *lady* & Tena *pants* Discreet: All areas except U, GMTV

Vagisil: STV

PharmaSite for next week: Voltarol – window, **Hayfever Care range –** in-store, **Canesten oral –** dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

A survival guide to PAYE

David Jervis unravels the mysteries of Pay As You Earn and the pitfalls to avoid

PAYE is the system whereby employers collect and account to the Inland Revenue for income tax and National Insurance Contributions (NICs) on their employees' salary, bonus and certain benefits.

All employees and officers of a company are subject to Schedule E income tax.

The PAYE obligation does not cover self-employed workers who are responsible for their own income tax and NICs.

If a worker is wrongly treated as self-employed the employer will be liable for the PAYE and NICs which should have been deducted and may not be able to recover the full amount from the employee.

Employees are subject to Schedule E income tax not only on all wages or salaries but also on any other profits earned from the employment. This includes bonuses, commissions, tips and some benefits in kind.

Payments to induce an employee to take up employment or to leave employment are also usually subject to tax and should be accounted for under the PAYE system. A partial exemption for payments up to £30,000 may be available for payments made to departing employees.

Whether a benefit in kind is taxable or not depends on the employee's level of earnings. Certain benefits are chargeable to income tax for all employees whereas others are only chargeable for directors or employees earning at least £8,500 per year. The income tax and NICs on certain benefits in kind are also payable by the employer under the PAYE system.

All employees will be chargeable to income tax on any 'readily convertible assets' such as shares which the employee can sell quickly and convert into cash.

Other benefits chargeable for all employees include payments made in vouchers and the discharge of a loan by the employer.

However, certain vouchers are exempt from the charge to income tax including some transport vouchers and vouchers in connection with sporting and recreational facilities. Luncheon vouchers are also exempt up to a value of 15p per day.

Directors and employees earning more than £8,500 per year will also be subject to income tax on certain other benefits. These include company cars, the provision of medical insurance and discounted loans made to employees. The tax on these benefits is payable by the employer under the PAYE system.

It is not only benefits provided by an employer which are taxable but also those provided by third parties. Tips or gifts from customers and suppliers, incentive award schemes or entry in a prize draw are also caught.

If the award scheme is a suggestion scheme which encourages employees to suggest ways of improving efficiency then provided such schemes meet certain conditions and the awards do not exceed certain limits there will be no charge to income tax.

For benefits which are shared among several employees, for example the provision of social functions, it may be possible to enter into a PAYE settlement agreement with the Inland Revenue. This allows an employer to make a single annual payment covering the income tax and NICs due on the benefits and again avoids the need to account for such items through PAYE.

Employers have both monthly and end of year recording and reporting obligations.

Form P11 should be completed each month recording all employees' pay and deductions. Monthly payments in respect of income tax and NICs must be recorded on form P32 and payment should reach the Inland Revenue by day 19 of each month. However, for smaller employers whose average monthly payments are less than £1,500 it is possible to pay quarterly instead of monthly.

At the year end the employer must send to the Inland Revenue form P14 showing a summary of all pay and deductions and form P35 showing the total tax and NICs deducted for all employees. Forms P11D and P9D must also be completed for any benefits in kind received.

Forms P14 and P35 must be returned by the May 19 following the end of each tax year and forms P11D and P9D by July 6. Penalties will be incurred if these forms are returned late.

Interest will be charged on any amounts outstanding at the end of the tax year which are not paid by the following April 19.

There are heavy penalties for the late filing of end of year returns. For late P14s and P35s the penalty is £100 for every 50 (or part of 50) employees for every month or part month that the return is late. For P11D and P9D the penalties are at the tax districts' discretion, however they can be up to £60 for each day that the returns are late. If the P11D or P9D is completed fraudulently or negligently the employer can be liable to a penalty of up to £3,000.

More information on the PAYE system can be found in the employer section of the Inland Revenue website at *www.inlandrevenue.gov.uk*.

David Jervis is a partner of solicitors' firm Eversheds.

Chemist Druggist & Levonelle levonorgestrel

EHC – managing the dialogu

THE COLLEGE OF PHARMACY PRACTICE

This tutorial has been designed to meet the requirements of the College of Pharmacy Practice in providing one hour of postgraduate education towards the College's continuing education requirement

There is more to supplying EHC than just knowing how the product works. Providing the right environment and being aware of your customers' sensitivities are important elements of successfully managing a transaction

Objectives

- To know the RPSGB guidance on dealing with requests for EHC
- To understand your customer's key concerns and sensitivities
- To be aware of the importance of managing the dialogue with the customer properly
- To be able to advise customers on appropriate self-treatment
- To know what sort of additional information women may need

Progestogen-only emergency hormonal contraception (EHC) is now the first-line choice for women at risk of unwanted pregnancy. Two 750mcg doses of levonorgestrel, taken orally 12 hours apart, starting within 24 hours of unprotected sex, will prevent 95 per cent of expected pregnancies. The risk of side effects is low, and serious adverse events are very rare.

There are three main ways for women to obtain EHC: on NHS prescription; under patient group directions (protocols) from clinics and some pharmacies; or as the Pharmacy medicine, Levonelle. In some areas, both PGD and OTC routes of pharmacy supply are available.

Royal Pharmaceutical Society guidance advises that the pharmacist must deal personally with EHC requests and should not normally make supplies to a third party. If the pharmacist decides that supply is inappropriate, he or she must refer the woman on to other sources of help.

Wherever possible, pharmacists should also take "reasonable measures" to provide information on the availability of regular long term contraceptive methods, and on reducing the risk of sexually transmitted diseases. This makes a request to buy EHC a very different experience from a request for other P medicines, and also from purchasing other types of contraception.

How do women feel?

Recent research by Schering, manufacturers of Levonelle, with customers and pharmacists has highlighted a clear gap between the actual and the ideal experience for women buying the product.

Women who decide to buy EHC may experience a range of emotions linked with the uncertainty of their situation. For some the overwhelming reaction may be anxiety ("I just can't get pregnant"); others may feel guilty, ashamed, or frightened of being "labelled". On top of this is the time pressure of the 72-hour window, and the fact that this is an unfamiliar situation over which they do not have total control.

Once they have found where they can obtain EHC the next step is to go in and ask. Surveys of women using the PGD supply route reveal that what they like most about pharmacy supply is the ease of access and the anonymity. However, in Lambeth, Southwark & Lewisham more than one in five women returning an anonymous questionnaire made comments about the lack of privacy and confidentiality.

Your perspective

EHC is unlike almost any other product. It's a contraceptive – but one to be used after the event. A request instantly reveals intimate information: you know this woman has recently had sex and that for one reason or another, the act was unprotected. Her behaviour may sit uncomfortably with your own moral views.

Your own views on this are important, because they could influence the way you interact with the client. Using a "paper patient", researchers from Leeds found that the attitude of health professionals, and their planned actions, were significantly affected by information on marital status, job, and previous use of EHC.

So first of all, think about and acknowledge the way you feel. Then try and set your own views aside because with EHC, efficacy is the primary issue.

Put yourself in her shoes

The customer is being responsible. She does not want an unplanned pregnancy. If she were not worried, she would not be there. She wants to use emergency contraception now. Your task is to weigh up the evidence and decide if EHC is suitable for this woman on this occasion.

The typical EHC client is likely to be in her 20s or 30s. She may seem outwardly confident but she is unlikely to relish making the initial request.

A request for supply should be passed straight to the pharmacist, but at busy times he or she may not be available immediately. Experience in PGD pilots found that women did not mind waiting, provided they understood why. Proper training of pharmacy staff can help 'filter' requests for EHC during peak periods.

The right environment is important, both for her and for you. You need somewhere where you will not be overheard or interrupted. The open plan layout used in many pharmacies can make this difficult.

Women want privacy but they also want to feel in control, so isolating them in a separate room is not necessarily the best option. Sometimes a quiet corner of the shop, with the client positioned so she can look out and see what is happening, can be better than using a closed-off dispensary area.

Once you see the client, what works best will often depend on the situation.

Key Do's and Don'ts

DO:

- Reassure the client that she is doing the right thing
- Focus on her needs now – will EHC be suitable?
- Be supportive – try not to judge what has led up to her request
- Ask her if she has any questions or concerns
- Reassure her on confidentiality
- Brief all relevant staff on procedure for handling EHC requests
- Obtain a list of local FPCs and GUM clinics, with opening hours and have them to hand for those women you need to refer

DON'T:

- Leave her waiting without an explanation
- Ask questions in earshot of other customers
- Dwell on the details of the "accident" (she will tell you if it's missed pills. Otherwise, why do you need to know?)
- Lecture her on regular long term contraceptive methods (a leaflet in the bag will do for now)
- Scare her about risks of STDs (again, a leaflet, or information about other sources of help might be appropriate)
- Let her leave without information on other local sources of help

Need to know...

Some customers may not expect questions. Others may have been told by friends what questions to expect and what the "right answers" are. So explaining that you are not "checking eligibility" but helping her make the best choice is vitally important.

You need to know when she last had "unprotected" sex, and if this was the only time this month. You also need to know about her menstrual cycle to:

- check if she might be pregnant
- determine if she actually needs EHC.

Often, just asking: "When did it happen?" will elicit nearly everything you need. If you need to probe, do so gently and sensitively.

What is less appropriate is a lecture on regular long term methods of contraception, or the risks of sexually transmitted diseases. She may need this information, but this is not the right time to give it. Point her to local clinics, and put some leaflets in the bag with her Levonelle.

Efficacy is time-dependant and the cut-off point for supply is 72 hours after intercourse. Certain medicines and herbal products reduce efficacy, as do conditions that affect absorption. If the woman is already pregnant, EHC will not work, nor is there evidence that the foetus will be harmed.

Questions about regular contraceptive methods are another sensitive area. Pharmacy supply of EHC offers a "way in" to mainstream sexual health services, and pharmacists should be naturally concerned to channel young women who have not used any contraception along this route. Teenagers may not know what is available, or not want to go to their GP for fear that their family will find out. Older women buying EHC are less likely to fall into this group.

Dispelling the myths

Women using EHC want information and facts. Ask them what their concerns are and make sure they know that you are there to answer any questions. While knowledge of when and how to take EHC is quite good, women still greatly overestimate the risk of being sick (the real figure is around 6 per cent).

They may also be confused about long term effects. In a survey of 30 women who had taken EHC in the past three months, half thought increased BP was a side effect. Two thirds thought that using EHC twice in a year was more dangerous than taking the Pill, and the same proportion thought that too frequent use would make EHC ineffective.

Another concern among women is that EHC will disrupt their monthly cycle: in reality most periods arrive within three days of the expected date of onset.

Customers tend to assume that Levonelle will be 100 per cent effective. Pharmacists should caution them that this is not the case, and that if their period is more than five days late they should check whether they are pregnant.

Information sources

www.levonelle.co.uk

For clients: *www.fpa.org.uk/guide/emergency*

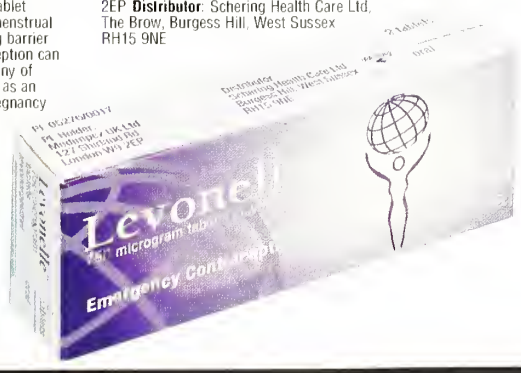
For pharmacists:

www.cppe.man.ac.uk/ehc/reqehc.htm

FPA clinic finder:

www.fpa.org.uk/helpnow/where/clinic.htm

LEVONELLE PRESENTATION Two tablets, each containing 750(g levonorgestrel. **Uses:** Emergency contraception within 72 hours of unprotected intercourse or failure of contraception. Not recommended for women under 16 without medical supervision. **Dosage and administration:** One tablet as soon as possible after unprotected intercourse (maximum of 72 hours afterwards), followed by the remaining tablet 12 hours (and no later than 16 hours) after the first dose. Vomiting within 3 hours of taking either tablet might impair efficacy. Another tablet should be taken immediately. Use at any time in the menstrual cycle unless period is overdue. After use, advise using barrier methods until next period. Regular hormonal contraception can be continued. **Contraindications:** Hypersensitivity to any of ingredients. **Warnings and precautions:** Suitable only as an emergency measure. Levonelle does not prevent a pregnancy in every instance. If timing of intercourse is uncertain or occurred more than 72 hours earlier, conception may have already occurred. Following treatment if the next menstrual period is abnormal or more than five days late women should be referred to a doctor, so that pregnancy may be excluded. Not recommended for women with severe hepatic dysfunction. Repeat administration within a menstrual cycle is not advisable. Efficacy might be impaired in women with malabsorption syndromes or by interaction with concurrent drugs including barbiturates (primidone), phenytoin, carbamazepine, herbal medicines containing Hypericum perforatum, rifampicin, ritonavir, rifabutin, griseofulvin. Medicines containing levonorgestrel may increase the risk of ciclosporin toxicity. Levonorgestrel is secreted into breast milk. Advise breast feeding women to take tablets immediately after a breast feed. **Side-effects:** Nausea, low abdominal pain, fatigue, headache, dizziness, breast tenderness, vomiting and diarrhoea. Bleeding patterns may be temporarily disturbed. **Trade price:** £13.28 per 1 x 2 tablets. **Legal classification:** P. **PL Number:** 05276/0017 **PL Holder:** Medimpex UK Ltd, 127 Shirland Road, London W9 2EP. **Distributor:** Schering Health Care Ltd, The Brow, Burgess Hill, West Sussex RH15 9NE



Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our Telephone Marking Service on **08705 112204** for an immediate result. You will be asked for the Tutorial Number. This tutorial is No27. Just listen to the instructions and press buttons 1 or 0 to indicate your answers. "1" indicates true; "0" indicates false. The telephone line will close on August 8, 2003. Please note that calls are charged only at standard national rates.

This module also appears on the *C&D* website, *www.dotpharmacy.com* under 'Education'.

If you want a certificate to confirm you have completed this College of Pharmacy Practice accredited course, complete the form below and send the original (or a photocopy) to: Mary Prebble, Pharmacy Editorial Projects, CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Please enter your name and status (please tick), pharmacy address and RPSGB/PSNI number (if applicable) below:

Name

Address

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1 Progestogen-only EHC will prevent 95 per cent of expected pregnancies if taken within 24 hours of unprotected intercourse
❑ True ❑ False

2 Pharmacists should deal with every request for EHC but can normally make supplies to a third party
❑ True ❑ False

3 Women requesting EHC often feel under pressure from a 48-hour time window
❑ True ❑ False

4 The attitude of pharmacists towards EHC customers can be significantly affected by knowledge of the customer's marital status
❑ True ❑ False

5 EHC is not effective if a woman is already pregnant, but may damage the foetus
❑ True ❑ False

6 The typical EHC client is likely to be in her late teens or early 20s
❑ True ❑ False

7 Women want privacy *and* to feel in control when requesting EHC
❑ True ❑ False

8 When going through the eight questions you need to ask, you should explain to the customer that you are checking their eligibility for treatment
❑ True ❑ False

9 You must tell every customer about regular methods of long term contraception and provide a list of local family planning clinics
❑ True ❑ False

10 Women should be advised to check if they are pregnant if their period is more than five days late after using EHC
❑ True ❑ False

Registered post

What are the attitudes in community pharmacy to pharmacy technician registration? , pharmacy graduate, gauged opinion as part of her final year project

The registration of pharmacy technicians will be a reality from 2005, largely based on debates amongst the pharmacist intelligentsia. This move has been influenced by two significant factors: the moves to modernise health services, and the expansion of roles for both pharmacists and technicians.

An important part of regulation of any professional group is the development of a membership register. By having a defined membership list it is possible to restrict who can practise; to identify entry criteria for membership, and to allow monitoring and disciplinary action to be taken where necessary. Pharmacists will recognise many of these elements of regulation from the processes that apply to the *Register of Pharmaceutical Chemists* maintained by the RPSGB. Within the modernisation of health services in the UK, systems of professional regulation are being further developed, for example with the widespread implementation of mandatory CPD for many professional groups.

In December 2002 the Council of the RPSGB decided to introduce mandatory technician registration from January 2007, subject to Government approval which was obtained in April this year, and changes in legislation which will be drafted during 2003. There is, however, little published information relating to the attitudes of pharmacy technicians, particularly those working in community pharmacy, to registration.

As part of my final year's studies I conducted a study of the attitudes among community pharmacy technicians towards registration using a postal questionnaire. It covered several topics, including attitudes towards registration and the registering body entry requirements for registration; opinions about a retention fee; and details about the technician, such as how long they have worked as a pharmacy technician and if they are a member of the Association of Pharmacy Technicians UK (APTUK). As technicians are not yet registered it is difficult to define who is a 'community pharmacy technician' felt it was important not to restrict the definition t individuals who hold specific qualifications, particularly in view of the proposed 'grandparent' clause that will allow certain experienced pharmacy st to be registered when the RPSGB sets up the register. F my study, I considered anybody working in a technician ro and who is involved in the dispensing process in a communit pharmacy to be a community pharmacy technician.

I sent questionnaires to two groups of community pharma technicians. The first comprised individuals identified as community pharmacy technicians who receive mailings fron WCPPE (group A). This information was extracted fro the WCPPE database. In addition, a second set of questionnaires was sent to each community in t former Gwent Health Authority area with a covering letter asking for any community pharmacy technician working there to complete a form (group B). All questionnaires were sent with some background information about the is so that they could make informed comments about the questions.

Registration and the registering body

Fifty two technicians from group A a 24 from group B responded to the questionnaire. A high percentage of the technicians surveyed were unaware of the proposed register prior to receiving the questionnaire. However, group A respondents w

receive educational mailings from the WCPPE were more aware of the issue than the group B technicians, indicating that even this relatively low level of support has an impact on 'professional' behaviour.

The majority of community pharmacy technicians were in favour of technician registration, with 86.5 per cent of group A and 83.3 per cent of group B agreeing. Most of those questioned also thought that registration should be compulsory for all those who want to practise as a pharmacy technician, but opinions were divided about who should maintain the register. Many of group A technicians felt that the APTUK should be the registering body, while most of group B were more in favour of the RPSGB.

There was also debate over the role of the registering body. Technicians expeeted help towards their professional development and educational support from the registering body, in addition to more predictable roles such as controlling entry to the register. Some of the roles suggested by the technicians would be inappropriate for a regulatory body, and would be more suited to a trade union. This leads to our suggestion that the RPSGB should be the registering body, taking on the regulatory roles, while a separate body, such as the APTUK, takes on the trade union role. It is interesting that these comments mirror the concerns of pharmacists regarding the role of the RPSGB as the Society's Royal Charter is renewed.

Entry requirements for registration

Technicians felt that there should be some assurance of the individual's competence before registration. This could be achieved in several ways including speeifying certain qualifications such as the NVQ Level 3 in pharmacy services as an entry route for membership, recognising qualifications that have been superseded by the NVQ, such as BTEC in pharmaeeutical scienees or through several years of experience working in a technician role. There was a strong feeling that there should be a grandparent clause to include experienced technieians who do not hold a formal pharmaey technician or dispensers qualifieation to avoid unneeessary retraining.

There was an apparent degree of misunderstanding about how the qualification criteria will work. Many technicians were eoneerned that their older qualifications would be worthless and that they would not be able to register. One respondent commented: "I would expect inelusion onto a register, even though I studied in the 1970s." It is also important that those technicians with a wealth of experience are not made to feel second-class.

For a two-year period to January 2007, technicians who do not hold the NVQ are likely to be allowed to register based either on their past experienee or certain qualifications which pre-date the NVQ. It is extremely unlikely that people holding older qualifications will be forced to return to college and retrain in order to register. Individuals who do not hold a qualification that is a recognised route to membership of the register, but are experienced working in the technician role, will also be allowed to register during this two-year voluntary registration period. However, their application may need to be aeeompanied by a signed declaration from a pharmacist that confirms their experience and competence.

It is now up to the RPSGB, which will be the registering body, to clarify which qualifications will be adequate for registration. This should be done as soon as possible to allow people to make informed decisions about their future careers.

Maintaining registration

The Department of Health has called for mandatory CPD for all health professionals and when technicians are registered they will be expected to comply with this requirement. It is therefore almost inevitable that technicians will have to satisfy some sort of revalidation criteria in order to maintain their registration, as pharmacists, doetors, nurses, dentists and other health professionals are required to do.

The majority of technicians in my survey felt that it should be compulsory to undertake some form of continuing professional development (CPD) or continuing education (CE) in order to stay on the register of pharmacy technicians. This proposal was most popular with those who had qualified in the last five years, but was not influenced by the number of hours worked by the technician each week.

In general, the technicians agreed that a retention fee would be necessary in order to cover administration costs and so that the registering body can support its members. Most people suggested that an amount between £50 and £100 would be appropriate. There was a disagreement over whether the technicians should have to pay the fee themselves, or whether their employer should pay it. However, it is most likely that each individual technician will have to pay their own retention fee, in the same way that other health professionals do.

Other effects of technician registration

The greatest and most desirable effect of technician registration highlighted by the respondents was an increase in salary levels. One person commented: "I feel that I have worked extremely hard in retail pharmacy for a very poor salary." Some people also stated that this would be a good opportunity to remove the inequalities in pharmacy technician wages between the hospital and community seetors. It may also allow a greater distinction to be made between registered pharmacy technicians and other unregistered dispensary staff.

Summary

The results from my study discussed above indicate that, when asked, most community pharmacy technicians are in favour of registration and the associate regulatory processes that would follow. It is a concern, however, that so few of the technicians surveyed understood what progress was being made regarding the development of a register. Community technicians need to be made awarc of the implications of registration in order that their views and concerns can be adequately considered as the detailed workings of the proposed register are finalised.

In addition, registration will carry increasing expectation for recognition and reward for community pharmacy technicians.

Acknowledgeneuts

This article is based on a final year MPharm undergraduate project supervised by Dr DJ Teuple and Mr G Thompson, director and deputy director respectively of the Welsh Centre for Post Graduate Pharmaeeutical Education. The advice on technician training and qualification matters provided by Lesley Morgan MBE is also gratefully acknowledged.

Anna Collyer studied at the Welsh School of Pharmacy, Cardiff

Plotting the

Education shouldn't stop once you qualify as a pharmacist. Fawz Farhan of Mediapharm looks at what postgraduate courses are on offer

The Schools of Pharmacy have had a busy year. Many have been developing new and innovative courses to meet supplementary prescribing and mandatory continuing professional development as they are introduced over the next year or so.

Flexibility in delivery of courses, so that practising pharmacists can fit learning into their working practices, has therefore been paramount to course designers. Information technology has also given Schools the opportunity to exploit new pedagogical approaches to enhance learning.

Meanwhile, the shortage of pharmacists has led to other universities looking to set up new Schools of Pharmacy to meet local needs.

Who's doing what?

King's College London

The School of Pharmacy is currently awaiting accreditation by the RPSGB for its supplementary prescribing course for pharmacists, which it hopes to launch in September. It already runs a prescribing course for nurses and plans to teach the pharmacy course jointly with the School of Nursing.

Dr Barry Goodyer, head of pharmacy practice, believes multi-disciplinary learning is a vital ingredient for the supplementary prescribing course. The pharmacy department has had strong links with nursing for the last five years and setting up a joint course has been a natural progression.

Dr Goodyer says the course will also be offered as a mixture of web-based and face-to-face learning, rather than purely distance learning, which is the route that other course providers are going. "We will be looking at different types of pedagogical methods to enhance the learning experience."

The course will be aimed at both hospital and community pharmacists, but tutors will be sensitive to the different skills set for each.

King's is also continuing its Postgraduate Diploma/MSc in Primary Care and Community Pharmacy. The course consists of four modules which can be taken individually as certificates.

Further information

Tel: Anne Lovejoy on 0207 848 4838

E-mail: anne.lovejoy@kcl.ac.uk

Derby University

A new Primary Care Pharmacy MSc replaced the MSc in Community Pharmacy in January.

The course is delivered through distance learning and can be started at any time. An optional weekend school is being considered.

Bruce Warner from the Pharmacy Academic Practice Unit says the new course is aimed at all pharmacists working or hoping to work in primary care. It aims to provide pharmacists with the skills required to undertake many of the extended role opportunities that are now available in primary care. It also equips forward- thinking pharmacists to move across the boundaries of the profession into community pharmacy, PCT or practice-based roles.

When developing the course, the university recognised that PCTs were looking for formal accreditation of the skills needed to perform extended roles such as prescribing advice. In addition, it realised that with CPD becoming mandatory, the course would provide pharmacists working in primary care with a formal and relevant award.

The modular course is flexible and students can take any individual or mix of modules, although if progressing to MSc independent study, then at least one research method module must be taken. Each module comprises about 150 hours of work, costs around £315 and must be completed within six months.

Further information

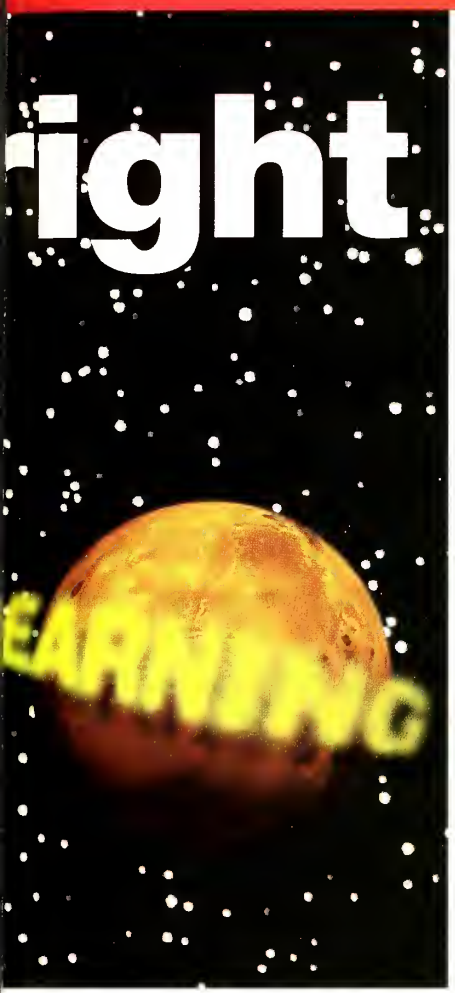
Tel: Bruce Warner 01332 592016.

Sunderland Pharmacy Schoo

The School is offering postgraduate certificates, diplomas and MSc in clinical pharmacy. Courses are modular open learning format and begin in September.

The first year is awarded a Certificate in Medicines Management. A second and third

right course



ear can be added on to form the Diploma and Masters respectively. Each year comprises 5.5 tudy days, bolstered with open learning packs.

Sunderland also runs an 'anticoagulation herapy management' two-day course and has new course for the autumn on 'supplementary prescribing for pharmacists', pending validation nd approval.

Senior lecturer Carol Candlish says interest as been "mega". "We have had hundreds of nquiries, mainly from PCTs and community pharmacists rather than hospital pharmacists."

Further information

Tel: Carol Candlish 0191 5152589.
E-mail: carol.candlish@sunderland.ac.uk

University of Bath

The University of Bath's 'advanced programmes in pharmaceutical practice and therapeutics', launched in February 2003, is a flexible, modular, part-time programme offering a choice of CPD or postgraduate certificate, diploma or MSc study. Self-paced learning through web-based study guides and printed materials is complemented by practice-based learning and face-to-face workshops.

There are two intakes a year (February and September) for the award-bearing programmes, but those interested in studying units for CPD can apply to join at any time. Bath currently has 21 learners studying for postgraduate awards.

Dr Andrea Taylor, co-ordinator for postgraduate education, says the department places particular emphasis on the development of knowledge for practice, as a key part of any pharmacist's professional development is practice and work-based experience.

"Pharmacists are encouraged to maintain a reflective practitioner diary, which will become an indispensable skill, not just through this programme, but for continuing professional development and their whole career."

The core materials are web-based study guides with learner support provided via the internet using an interactive 'virtual learning environment'. By choosing particular combinations of units there is a choice of graduating with a degree that reflects their area of professional interest:

- 'Clinical pharmacy practice (primary care)' – for the community and trust environment
- 'Clinical pharmacy practice (secondary care)'– for the hospital environment
- 'Pharmaceutical healthcare' – for the generalist
- 'Industrial pharmacy' – for the industry environment.

Further information

Tel: Dr Andrea Taylor 01225 384140.
E-mail: a.d.j.taylor@bath.ac.uk.

Keele University

The Department of Medicines Management is proud of its high student completion rate, fostered through emphasis on student support and planned, well-structured courses.

The department specialises in distance learning postgraduate courses. Pat Black, senior lecturer and postgraduate courses development manager, says: "We are acutely aware of the pressures on pharmacists that make it difficult to take time off work, or devote evenings or weekends to face-to-face courses. Open and distance learning (ODL) courses provide a great deal of flexibility for study. We also chose this method of delivery because we strongly believe that well-designed ODL courses are extremely effective – more so than 'conventional' face-to-face courses for many people."

At the same time Keele is strongly committed to supporting learners and students. A course team of tutors and administrative staff supports each course, and students can access them freely by telephone and e-mail. Although courses are mainly delivered at a distance from Keele, previous students and tutors have found it valuable to meet two or three times a year on campus.

Courses also emphasise the importance and value of reflective practice. "We realise that to embark on a postgraduate course at diploma or masters level is not something that every pharmacist needs, wants, or can fit into their life. With this in mind, we have structured our courses to offer 'drop-in/drop-off' options that should suit the majority and contribute to meeting personal CPD needs."

Short courses include 'Clinical pharmacy for Medicines Management', 'Prescribing support in primary care' and 'Prescribing studies'. The latter is suitable for pharmacists who work regularly within a GP practice/PCT giving prescribing advice, and also for pharmacists who have qualified as supplementary prescribers. The course is also available for GPs and other independent and supplementary prescribers, making them interdisciplinary and giving opportunities for shared learning. Longer certificate and diploma programmes include the 'Certificate in therapeutics and prescribing (community pharmacy)', 'Diploma in community pharmacy' and 'Certificate/Diploma in prescribing studies' planned for September 2003.

For pharmacists wishing to develop their research skills, Keele offers an MSc programme that is a third year added on to diploma programmes. It also offers a part-time MPhil/PhD programme for individuals who wish to pursue a higher degree by research.

Further information

Tel: Bev Oakden 01782 584207 or
Linda Foster 01782 584117.
E-mail: b.oakden@keele.ac.uk or
l.j.foster@keele.ac.uk

University of Brighton

The School of Pharmacy and Biomolecular Sciences is continuing its postgraduate diploma/MSc 'Community pharmaceutical health care' course in collaboration with the National Pharmaceutical Association. The course is 18 months long and students are required to study six modules and attend three residential weekends. Each module requires 100 hours of study, including practical work.

The next course starts in January 2004 and costs £2,900. Those enrolling need to commit to between eight and 10 hours of study weekly, have the co-operation and support of the local GP and be an NPA subscriber.

Further information

Tel: Dr R W Daisley on 01273 642080.
E-mail: r.w.daisley@brighton.ac.uk

London School of Pharmacy

The 'Postgraduate diploma/MSc in pharmacy practice' contains optional modules which can be taken as short courses by pharmacists to support their CPD.

Dr Soraya Dhillon, acting head of department of practice and policy, says the options which may be of interest to community or primary care pharmacists are:

- Health economics and public health
- Commissioning and primary care
- Care of older people
- Management and marketing
- Teaching and learning
- IT.

The clinical options require pharmacists to have access to acute patients and normally the pharmacist must hold a 'Certificate in pharmacy practice' before joining the course.

Future developments include a new diploma/MSc 'Medicines in healthcare', a joint initiative with Southbank University available to pharmacists, nurses, GPs and other healthcare professionals working in medicines management. Dr Dhillon adds that the School is currently developing a supplementary

Continued on page 30 ▶

prescribing course jointly with City University.

Further information

Tel: Dr Dhillon on 020 7753 5855.
E-mail: tpc@ulsop.ac.uk

De Montfort University

Leicester School of Pharmacy at De Montfort University offers its 'Postgraduate certificate in clinical pharmacy' as a four-module programme comprising eight distance learning packs. Students can progress to the diploma but this requires an intensive three to four day residential course in Leicestershire.

The School plans to reorganise the certificate and diploma in the very near future to ensure greater emphasis on the application of knowledge and reflective learning and provide greater flexibility in order to meet individual demands for CPD activities.

The MSc is negotiated on an individual basis by discussion with the programme leader.

Further information

Tel: Lindsay Taylor, programme leader for Postgraduate Distance Learning in Pharmacy 01162078128.
E-mail: lmt@dmu.ac.uk

Queen's University, Belfast

The School of Pharmacy at Queen's University, Belfast (QUB) offers a 'Postgraduate certificate/diploma/MSc in community pharmacy' via its distance learning centre.

QUB recognises that studying for a postgraduate qualification totally by distance learning provides an attractive alternative for pharmacists who find it difficult to attend taught, on-campus classes or residential study blocks. On the other hand, distance learning can potentially be a lonely experience and QUB staff have put considerable effort into developing support mechanisms for its distance learning students. The distance learning centre includes a full-time pharmacist manager and administrative staff. The centre staff are available by telephone and e-mail during office hours. In addition, students are encouraged to contact each other via the dedicated course discussion forum.

QUB also runs the distance learning 'Certificate in community pharmacy management' in collaboration with *Community Pharmacy*. Meanwhile, the distance learning centre and the Northern Ireland Centre for Postgraduate Pharmaceutical Education and Training are collaborating in the development of a 'Postgraduate certificate in prescribing for pharmacists' for those pharmacists in Northern Ireland who wish to become supplementary prescribers. Initial intakes will be limited to hospital pharmacists. However, it is intended that the course will be open to community pharmacists within 12 months when the necessary legislation should be in place to allow community pharmacists in Northern Ireland to become supplementary prescribers.

Further information

Tel: Brian McCaw, distance learning centre manager on 028 9027 2004.
E-mail: b.mccaw@qub.ac.uk

News roundup

New Schools of Pharmacy

Three new Schools of Pharmacy are scheduled to open to help address the shortage of pharmacists in the United Kingdom.

The University of East Anglia school of pharmacy opens this September and has just appointed Professor Duncan Craig as its head. The Medway School of Pharmacy at Chatham Maritime, which has been set up by the Universities of Kent and Greenwich, opens its doors to students in September 2004, while Anglia Polytechnic University in Cambridge is scheduled for opening in 2005.

Meanwhile Kingston University and the University of Leeds are seeking to set up Schools of Pharmacy too.

Innovations In Education fayre

The pharmacy department and the Institute of Dentistry at King's College London are staging a fayre on 'Innovations in Education' on July 16, bringing together innovative healthcare professional CPD providers to promote better learning and delivery of education.

The show is open to all pharmacists and students. The fayre will also be used to unveil the results of the European-funded online CPD pilot for community pharmacists and dentists. The fayre is being held at The Park, Guy's Hospital, London Bridge 11am–4pm.

Further information

Tel: Sue Jones 0207 848 4847.

Knowledge Bridge

Knowledge Bridge is a free web-based resource of courses and training programmes offered by London's universities. The site is aimed at highlighting CPD courses to employers. Knowledge Bridge is funded by the Higher Education Funding Council for England. The project is led and managed by City University, London.
www.knowledgebridge.co.uk

Internet Pharmacist

Internet Pharmacist is a national web resource offering free online training in internet skills to practising pharmacists and to students, lecturers and researchers and is available on *www.vts.rdu.ac.uk/tutorial/pharmacist/*.

Internet Pharmacist is a free teach-yourself tutorial on the web, which offers step-by-step instruction in internet searching and information skills, such as critical evaluation. It also provides a guided tour of the highlights of the web for pharmacy. Online quizzes and interactive exercises lighten the learning experience and there is a glossary of internet terms and a 'Links basket' to collect a personal list of useful web links.

Is distance learning for you?

Study by distance learning may not suit everybody. The following points provided by Brian McCaw, distance learning centre manager at the School of Pharmacy of Queen's University, Belfast, will help the potential student to decide if they are suited to studying by distance learning.

- Most people who are successful with distance learning find it difficult to come to campus on a regular basis because of their work, family or personal schedules.
- Some students prefer the independence of distance learning; others find the independence uncomfortable and miss being part of the classroom experience.
- Distance learning courses give students greater scheduling freedom, but they require more self-discipline than on-campus classes.
- Some people learn best by interacting with other students and instructors. Others learn better by listening, reading and reviewing on their own.
- Distance learning courses provide less opportunity for group interaction than most on-campus courses.
- Distance learning requires at least as much time as on-campus courses.
- Printed materials are the primary source of directions and information in distance learning courses.
- It can take several weeks to get comments back from tutors in distance learning courses.

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FREE LEGAL ADVICE

Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Rewarding excellence

Northern pharmacy chain Weldrick's held its annual presentation evening to celebrate the success of its staff and the company's success in achieving the Investors in People award for the fourth consecutive time. Certificates for NVQs at level 2 and 3 were presented for pharmacy services, warehousing and distribution, retail operations, management and customer service.

Guest of honour Mike Potts, who is the chief executive of Doncaster West PCT, said: "It was a pleasure to be invited to share in the celebration and to present so many awards for achievement. The individual recipients of the awards should be justly proud of their success, as should Weldrick's for their commitment to staff development and training."

Pictured, from the left, are: Maureen Warren, Marilyn Jones, Leeanne Hill, Mike Potts, Lynsey Creber, Lesley Jones

Weldrick's training manager Marilyn Jones said: "It's great to acknowledge the achievements made by our staff in all areas of the business. An evening like this gives us all the chance to celebrate."

Sunayana Shah (centre), scientific and medical affairs manager at the Proprietary Association of Great Britain, is pictured with this year's two Professional Learning Programme award winners at the Association's annual dinner. The PLP course sets a standard of knowledge within the OTC industry to enhance the professionalism of representatives who call on pharmacists and the award is given to the top candidate for each examination sitting. On the left, Phil Francis of GSK, was the winner from the March exam and Mark Baker, of DDD Limited on the right, was the best candidate for last October's exam. Does this mean they automatically know when to call on you as you're about to run out of pens and note-pads? Hope so

Mystery hawthorn delivery

C&D staff like a little investigative work to get to the bottom of a good story but this one has us stumped – temporaril of course.

The poor editor was seen staggering down the office with a large box last week. It was nearly pay day but even he's discreet enough to have his salary delivered to his home address. Was it that order from the Ann Summers party that a nameless member of staff had been to? N – it was 10 hawthorn bushes. Research so far has revealed that hawthorn is used as a cardiotoni hypotensive and antisclerotic agent but the source of these delightful plants, now happily growing in the company garden remains unknown.

Is someone concerned for our cardiac health? Is it the Listenin Friends scheme trying to make sure the news editor doesn't pop cork the next time he hears the words 'draft Charter'? Has *Xrayser* upset the Pharmacy Hawthorn Appreciation Society Or is it one of those PR stunts t get the column inches they were so desperately seeking? It'll nev work with us.

Answers on a postcard please

Keeping it in the family

Pictures never lie, or so they say, and the Sharpes (PSNC boss Sue and one-time RPSGB head boy David) appear to be dancing to the dulcet tones of club crooner Rajni Hindocha (aka CAMRx boss) at last weekend's CAMRx convention in Bedfordshire.

However, the merriment was due to Sue picking husband David's raffle ticket as the winning entry, and despite cries of 'foul play' and careful checking of the small print, he was allowed to keep his prize of T shirt and golfing towel.

United Co-op Pharmacy was a sponsor of the 22nd Potteries Marathon. The Group provided a range of health checks from a marquee by the start and finish line and plenty of United employees took part in the accompanying relay race. Business development manager Simon Hay explained to BBC Radio Stoke listeners how United operates pharmacies throughout the Potteries and cuts queues in surgeries by treating minor illnesses

Wyeth

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As Seen On TV

Bazuka that verruca

NO NEED FOR PLASTERS

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